BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING AGENDA

Date: Wednesday, February 12, 2025
Time: 18H00 – 19H00
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Attachment
18:00	**1. Call to Order**	
(1 min)	1.1 Confirmation of Quorum	
(1 min)	1.2 Adoption of the agenda	P. 1-2
(1 min)	1.3 Declaration of Conflict of Interest	
18:03	**2.Report from Last Meeting**	
(1 min)	2.1 Approval of previous meeting report – November 13, 2024	P. 3-6
(1 min)	2.2 Business arising from the report	
(1 min)	2.3 Committee Work Plan Check In	P. 7
18:06	**3. Education Session**	
(10 min)	3.1 Patient Story (R. Romany)	
18:16	**4. Matters for Discussion/Decision**	
(10 min)	4.1 Professional Staff Appointment and Re-appoint Review (Dr. L MacKinnon) **THAT the Quality and Risk Management Committee review and receive the Professional Staff Appointment and Re-appointment Report as presented.**	P. 8-21
(5 min)	4.2 Quality of Care Information Privacy Act Policy (R. Romany) **THAT the Quality & Patient Safety Committee recommend to the Board of Directors the adoption of the Quality of Care Information Privacy Act Policy for regular review.**	P. 22-27
(5 min)	4.3 Review Q3 Quality Improvement Plan Results 2024/2025 (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Quality Improvement Plan Results for 2024/2025 as presented.**	P. 28-31
(5 min)	4.4 Quality Improvement Plan 2025/2026 (R. Romany) **THAT the Quality & Patient Safety Committee recommend to the Board of Directors the approval of the Quality Improvement Plan for 2025/2026 and the QIP narrative as presented.**	P. 32-40
(5 min)	4.5 Review Q3 Quality & Safety Scorecard Results (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Quality & Safety Scorecard results as presented.**	P. 41-42
(5 min)	4.6 Review Q3 Patient Satisfaction Survey Results (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Patient Satisfaction Survey results as presented.**	P. 43-46
(5 min)	4.7 Review Q3 Violent Incident Report (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Violent Incident report as presented.**	P. 47
(5 min)	4.8 Review Q3 Complaints and Compliments Report (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Complaints and Compliments report as presented.**	P. 48-49
19:01	**5. Matters for Information**	
(2 min)	5.1 Patient & Family Advisory Committee Update (R. Romany)	P. 50
(5 min)	5.2 Best Practice Spotlight Organization Update (R. Romany)	P. 51-52
(5 min)	5.3 Accreditation Updates (R. Alldred-Hughes)	P. 53-54
(5 min)	5.4 Accreditation Standard Review (R. Romany)	P. 55
(5 min)	5.5 Review Status of Patient Safety Plan Actions (R. Romany)	P. 56-69
19:23	**6. Date of Next Meeting**	
	Wednesday, May 14, 2025	
19:24	**7. Adjournment**	

*Refer to the Accountability for Reasonableness (A4R) framework for organizational ethical issues.

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps

Determine and Identify

- Determine your mandate and the key question.
- Identify stakeholders and involve them in decision-making.
- Ensure alignment on the problem and question.

Clarify and Provide

- Clarify decision-making procedures (values, strategic priorities)
- Share how decisions will be made and revisited.
- Document rationale for decisions using value-based criteria.

Communicate

- Communicate decisions and their rationale with stakeholders.
- Seek input on communication strategy.

Revisit and Revise

- Revisit decisions as needed based on new evidence or stakeholder input.

Evaluate and Improve

- Evaluate success based on "accountability for reasonableness".
- Identify gaps and implement improvements for future processes.

REPORT OF THE BOARD QUALITY AND RISK MANAGEMENT COMMITTEE MEETING

November 13, 2024 at 7:00PM in the Boardroom / MS Teams

Present:	C. Larocque W. Rozon R. Alldred-Hughes	Dr. S. Robertson H. Salib Dr. R. Cardinal	G. Peters R. Romany
Regrets:	C. Mageau-Pinard	Dr. L. MacKinnon	

DRAFT

Summary of Discussion

Approval of the Agenda:
The agenda was reviewed.

Moved By: Dr. R. Cardinal
Seconded By: H. Salib
THAT the agenda be approved as presented.

CARRIED

Declaration of Conflict of Interest:
There were no conflicts declared.

Report from the Previous Meeting:
The report from the meeting of September 11, 2024, was shared and amendment made to the number of patients seen in the Emergency Department under Review Q1 Complaints and Compliments Report.

Moved By: G. Peters
Seconded By: W. Rozon
THAT the report be approved as presented.

CARRIED

Business Arising from Report:
There was no business arising from the report.

Committee Work Plan Check In:
The HIROC report was moved to later in the committee cycle as it is not available as of yet.

Education – Patient Story (R. Romany)

R. Romany presented a patient story in which a patient was to be transferred to the hospital however, required dialysis three (3) times per week in which the patient would have needed to be transferred back and forth to another hospital since this is not a service that is provided at HGMH. As such, the patient was repatriated to the other hospital instead as this situation was not ideal for the patient.

R. Romany explained the purpose of the regional patient repatriation program and that understanding the specific needs of each patient helps ensure that they are transferred to the right facility.

Matters for Discussion/Decision

Review Q2 Quality Improvement Plan Results 2024/2025
The Q2 Quality Improvement Plan results were reviewed.

Moved By: H. Salib
Seconded By: W. Rozon
THAT the Quality & Patient Safety Committee review and receive the Quality Improvement Plan Results for 2024/2025 as presented.

The metrics were reviewed. The percentage of patients who visited the Emergency Department and left without being seen by the physician was slightly higher than the target however, having the additional physician for four-hour blocks on the busier days has greatly improved this.

The number of reported near misses related to controlled substances within the organization was negatively above the target of 12 reported incidents. Lots of work is being done on narcotic diversion and this will also be done at orientation for new clinical hires. It was noted that because there is so much focus on this at the moment, reporting has increased which isn't a negative thing as reporting is important in order to be able to make change. Since these are near misses, these incidents did not reach the patient which is the important thing.

All other metrics are trending well.

CARRIED

Review Q2 Quality & Safety Scorecard Results
The Q2 Quality & Safety Scorecard results were reviewed.

Moved By: H. Salib
Seconded By: W. Rozon
THAT the Quality & Patient Safety Committee review and receive the Q2 Quality & Safety Scorecard results as presented.

R. Romany presented the results from the Q2 Quality & Safety Scorecard and the areas for opportunities including fall rates, c-difficile rate, and pressure injury development rate during inpatient stays which all finished over target in Q2.

To improve fall rates, the clinical team will be focusing on individual care plans, medication reviews, environmental modifications, patient and family education, and more frequent monitoring of the patients.

The c-difficile rate came in slightly over target. To improve this metric, hand hygiene compliance will be reinforced and refresher education on the use of personal protective equipment will be done.

One stage 2 pressure injury was acquired during the stay of an inpatient. Focus will be emphasized on high-risk patients with limited mobility, inadequate nutrition, and coexisting health conditions.

CARRIED

DRAFT

Review Q2 Patient Satisfaction Survey Results
The patient satisfaction survey results were reviewed.

Moved By: Dr. R. Cardinal
Seconded By: G. Peters
THAT the Quality & Patient Safety Committee review and receive the Patient Satisfaction Survey results as presented.

Overall, patients seem satisfied with the hospital. Work will be done on improving communication with patients as this seems to be the biggest gap.

CARRIED

Review Q2 Violent Incident Report
The Q2 violent incident report was reviewed.

Moved By: Dr. S. Robertson
Seconded By: H. Salib
THAT the Quality & Patient Safety Committee review and receive the Violent Incident report as presented.

There were no violent incidents reported in Q2.

CARRIED

Review Q2 Complaints and Compliments Report
The Q2 complaints and compliments report was reviewed.

Moved By: H. Salib
Seconded By: W. Rozon
THAT the Quality & Patient Safety Committee review and receive the Complaints and Compliments report as presented.

Five formal complaints were received for the Emergency Department, mostly around the adequacy of care and the attitude of staff. No complaints were received around wait times. All of the patients who submitted a complaint were contacted and were satisfied with the discussions that took place.

Five compliments were also received during Q2, all related to the care received in the Emergency Department.

CARRIED

Review Critical Events and Never Events Report
The critical events and never events report was reviewed.

Moved By: Dr. R. Cardinal
Seconded By: H. Salib
THAT the Quality & Patient Safety Committee review and receive the Critical Events and Never Events report as presented.

The definitions of critical events and never events were explained. There were no events to report on.

CARRIED

DRAFT

Review Status of Patient Safety Plan Actions
R. Romany presented on the patient safety key behaviors and mentioned that with the IDEA committee now up and running, more is being done to make the organization an inclusive place. Patient and Family Advisory committee members are also actively engaged in initiatives.

Matters for Information

Patient & Family Advisory Committee Update
The Patient and Family Advisory Committee have successfully completed their two initiatives which were to provide feedback on the Essential Care Partner program training and the work done on partnering with the SDG Library to provide access to admitted patients to ebooks.

The committee were actively involved in the planning for Patient Safety Week.

Best Practice Spotlight Organization Update
Work continues on the two Best Practice Guidelines. A new lead was assigned in the absence of one of our staff members.

Accreditation Update
We are currently at 85% compliance with Required Organizational Practices. These have been updated by Accreditation Canada and they have agreed to providing a crosswalk to highlight the scope of changes however, this has yet to be received. A letter was submitted to Accreditation asking to remain on the current manual and have updated ROPs apply for our next survey. While they have confirmed receipt of our letter, we have not received a response. If no response is received by December, we will start working on the new standards.

Staff were asked to complete the Accreditation Employee Engagement Survey. Results will be presented in January.

Accreditation Standard Review
R. Romany presented the Accreditation standard 3.1.12 The governing body demonstrates accountability for the quality of care provided by the organization.

Date of Next Meeting: February 12, 2025

K-L. Massia, Recorder

DRAFT

Quality & Patient Safety Committee
Work Plan 2024-2025

Deliverable	MRP	Occurrence	Sept	Nov	Feb	May
STRUCTURE/PROCESSES						
Review/Recommend Committee Terms of Reference	Chair	Annually	✓			
Review Committee Effectiveness Survey Results	Chair	Annually	✓			
Review/Recommend Annual Committee Work Plan to Governance	Chair	Annually	✓			
Professional Staff Appointment and Re-appointment Review	COS	Annually		X		
EDUCATION						
Patient Story	CNE		✓		X	
Quality Initiatives	CNE			✓		X
QUALITY OVERSIGNT AND IMPROVEMENT						
Review QIP Dashboard	CNE	Quarterly	✓	✓	X	X
Recommend QIP Dashboard 2025-2026	CNE	Yearly			X	
Clinical Quality & Safety Scorecard	CNE	Quarterly	✓	✓	X	X
Review Patient Satisfaction Survey Results	CNE	Quarterly	✓	✓	X	X
Violent Incidents Report	CNE	Quarterly	✓	✓	X	X
Review Life or Limb Results	CNE	When available				
Review Complaints & Compliments Report	CNE	Quarterly	✓	✓	X	X
PFAC Update	CNE	Quarterly	✓	✓	X	X
Review Critical Events and Never Events Report	CNE	Yearly		✓		
BPSO Update	CNE	Quarterly	✓	✓	X	X
Review Patient Safety Plan	CNE	Yearly			X	
Review Status of Patient Safety Plan Actions	CNE	Quarterly	✓	✓	X	X
Review Provincial Stroke Report Card	CNE	When available				
Review Ethics Committee Updates	CNE	Yearly				X
Review HIROC Report	CEO	Yearly				X
Review Emergency Preparedness	CNE	Yearly				X
ACCREDITATION						
Accreditation Updates	CEO	Quarterly	✓	✓	X	X
Accreditation Standard Review	CNE	Quarterly	✓	✓	X	X

Revisions since prior report:

- HIROC report moved to May as report is generally received in April

Updated July 10, 2024

~ 2025~

HGMH Professional Staff Appointment and Re-appointment Review

Board Quality, February 12, 2025

Presenter:

Dr. Lisa MacKinnon, MD, Chief of Staff

AGENDA

- What is “Credentialing”?
- Boards Obligation
- Medical HR
- Classifications of Professional Staff
- Process Flow
- Required Documentation for Application/Re-Application
- Common Credentialing
- Questions

WHAT IS CREDENTIALING?

- Credentialing includes a range of activities and processes, such as reviewing applications for initial appointments, verifying qualifications, identifying the scope and nature of privileges, granting privileges, performing periodic reviews, and conducting annual reappointments.

- The term "privileges" is used because Professional Staff are given the privilege of using hospital resources in return for providing care to hospital patients.

Reference: Professional Staff Credentialing Toolkit, 2021

WHO IS CREDENTIALED?

- Although a variety of health care professionals work in hospitals, credentialing is only required for physicians, dentists, midwives, and extended class nurses.

- These professionals are not generally employed by the hospitals. They are usually independent contractors who bill the Ontario Health Insurance Plan for their services.

BOARD OBLIGATIONS

- Under the Public Hospital's Act, only the hospital Board can grant, restrict or revoke physician privileges.
- The Board relies on the Chief of Staff (COS) and the Medical Advisory Committee (MAC) to make recommendations on privileges.
- Physicians are entitled to appeal to the board on privilege issues (e.g. restrictions, revocations, etc.).
- Procedural fairness is of utmost importance in this process.
- CEO & COS can temporarily grant, restrict or revoke privileges on an emergency basis, pending final approval at the next MAC and Board meetings.

MEDICAL HR

Having a clear picture of the medical HR landscape assists the organization with purposeful retention, recruitment, and risk management.

Newly-credentialed staff must support organizational needs, such as:

- Current and future care gaps (retirements, vacancies, specialist support)
- FR-EN language needs
- Inpatient and ER roster coverage

MEDICAL HR

Credentialing someone is easy. Revoking, restricting or not renewing privileges is more challenging!

Strategies for minimizing risk to HGMH or patients:

- Annual performance evaluations
- Strong record keeping of behavioral or professional misconduct
- Early risk identification and mitigation

CLASSIFICATIONS OF PROFESSIONAL STAFF

- **Active Staff:** Can admit, diagnose, treat, vote and hold office. Cannot be designated as active at another hospital.
- **Associate Staff**: Can admit, diagnose, treat, vote. Cannot be designated as active at another hospital. Will undergo performance evaluations at six-month intervals following the initial appointment. Performance will be reviewed by MAC prior to recommending appointment to Active Staff.
- **Courtesy Staff:** Is active staff elsewhere or wants limited access to HGMH resources/programs/facilities. Not obliged to attend staff meetings. Cannot vote or hold office.

CLASSIFICATIONS OF PROFESSIONAL STAFF

- **Locum Tenens Staff:** Can admit, diagnose, treat patients. Shall not attend or vote at Professional Staff meetings or be elected or appointed to any office of the Professional Staff. Meets specific clinical needs for a defined period of time in one or more of the following circumstances:

  a) to be a planned replacement for a Physician, Dentist, or Midwife for a specified period of time; or

  b) to provide episodic or limited inpatient, emergency or consulting services.

- **The Extended Class Nursing Staff:** The Board, having given consideration to the advice of the Medical Advisory Committee, will delineate the privileges for each member of the Extended Class Nursing Staff who is not an employee of the Hospital.

PROCESS FLOW
INITIAL APPOINTMENT

Every physician is entitled to apply for hospital privileges and have his or her application considered by the hospital in accordance with the hospital's by-laws and the Public Hospitals Act. With every application, the medical advisory committee must meet and make a written recommendation to the board.

Physician requests appointment package

Applications reviewed by Medical Affairs, Chiefs of Department, COS and CEO

MAC

Board of Directors

PROCESS FLOW
RE-APPOINTMENT

CMARS email Invite for re-appointment
(early November)

Final Notice
(early December)

Deadline
(late December)

Notice of Expiry
(early January)

Applications reviewed by Medical Affairs, Chiefs of Department, COS and CEO

MAC
(early January)

Board of Directors
(early January/February)

Written Board Approval for privileges to physicians (after Board meeting)

Required Documentation for RE-APPLICATION

- ✓ Re-appointment application - CMARS
- ✓ Pledge of confidentiality
- ✓ Proof of CMPA or other professional staff insurance coverage stating active coverage in Ontario
- ✓ Current ACLS/BLS certification (Emergency/Inpatient)
- ✓ Up to date N95 fit testing (all on-site physicians)
- ✓ Up to date HGMH education and attestations as required

COMMON CREDENTIALING

- The process of common credentialing allows hospitals to pool their Professional Staff resources more easily.
- A letter of good standing is requested from the site the professional staff is applying too to the site they currently have privileges at.
- The letter of good standing acknowledges what the site has on file for the professional staff. Should some documentation be missing from our standard list, the request can be made that the professional staff provide such documentation.

QUESTIONS?

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared:	December 12, 2024	Meeting Date Prepared for:	December 19, 2024 – Quality & Safety Advisory Committee, SLT meeting - Jan 14, 2025 Board Quality- Feb 12,2025
Subject:	Quality of Care Information Privacy Act (QCIPA) Policy		
Prepared by:	Rachel Romany, VP Clinical Services, Quality & CNE		

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To seek approval for the revised Quality of Care Committee Policy, now referred to as the Quality of Care Information Privacy Act (QCIPA) Policy, which outlines the updated process for conducting quality of care reviews.

MOTION

That the Quality & Patient Safety Committee recommend to the Board of Directors the adoption of the Quality of Care Information Privacy Act policy for regular review.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

- The Quality of Care Committee Policy was created in October 2006 and was last reviewed in June 2017. As such, this policy was due for review.
- The policy was revised and renamed the Quality of Care Information Privacy Act (QCIPA) to better reflect the nature of the policy.
- QCIPA is a key legislative framework that allows health care providers to engage in candid and confidential discussions to improve patient safety and quality of care.
- In alignment with QCIPA, the policy was revamped to focus on the process when doing a Quality of Care Review, enhance clarity regarding the roles and responsibilities when completing a review and strengthen protections for sensitive quality improvement information.

CONSULTED WITH:

Indicate those bodies and individuals who have been consulted with in the development of this decision support document

- Quality & Safety Advisory Committee – December 19, 2024
- Senior Leadership Team- Jan 14, 2025

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- The policy will be uploaded on the Intranet

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Draft Quality of Care Information Privacy Act (QCIPA) Policy

Document Name:	Quality of Care Information Privacy Act (QCIPA)	
Document Number:	BOD.03.002.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** N/A
Classification: Board of Directors	**Section:** Quality & Patient Safety	
Owner: Chief Nursing Executive	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The purpose of this policy is to ensure the confidentiality, integrity, and security of all information related to the quality-of-care reviews conducted by the organization. The organization is committed to continuous improvement of care quality, while safeguarding the sensitive information generated and reviewed during the quality care evaluation processes. All reviews shall be conducted with due diligence, fairness, and in accordance with legal, ethical, and organizational standards.

This policy outlines the criteria for conducting quality care reviews, the responsibilities of stakeholders involved, and the procedures for protecting quality care-related information in compliance with the Quality-of-Care Information Protection Act, 2004 (QCIPA), the Personal Health Information Protection Act (PHIPA), and other relevant privacy and legal protections such as the Canada Health Act, Accreditation Canada standards, Evidence Act (Ontario) within the Canadian healthcare setting.

SCOPE:

This policy applies to all hospital staff, healthcare providers, and committees involved in the process of reviewing, analyzing, and improving the quality of patient care.

PROCEDURE:

1. **Initiation of Quality Care Review**:
   - A quality care review will be initiated by the Chief of Staff and VP Clinical Services, Chief Nursing Executive based on identified care gaps, patient complaints, or scheduled routine reviews.

2. **Criteria for Review**: Quality care reviews will focus on, but are not limited to, the following criteria:
   - **Patient Safety**: Evaluating incidents of harm, preventable errors, medication events, and near-misses, e.g. sentinel, serious or adverse events.
   - **Care Coordination**: Assess communication effectiveness, the smoothness of care transitions, and the adequacy of follow-up care.

- **Patient -Centred Care:** Assessing patient satisfaction surveys, complaints and feedback regarding care delivery, and whether patients feel involved in their own care decisions.
- **Documentation:** Review the accuracy and completeness of patient chart to ensure they reflect the patient's care appropriately
- **Clinical Outcomes**: Reviewing patient outcomes, including readmission rates, and treatment effectiveness to identify trends or areas needing improvement.
- **Performance**: Evaluate staff performance and adherence to best practices and protocols.
- **Compliance**: Ensuring that care delivery complies with relevant laws, regulations, accreditation standards and organizational protocols that impact quality and safety.
- **Resource Utilization**: Evaluating the efficiency of care delivery in relation to resource consumption, including staffing, equipment, and facilities.

3. **Conducting the Review**:
    - **Restricted Attendance**: The review is a focused, restricted meeting to ensure that only clinical team members, leadership and other relevant departments involved in the patient's care are present. This ensures the discussion remains relevant and efficient, centered around critical patient outcomes. Invitations are extended based on roles or areas of expertise within the care process.
    - **Inclusion of essential team members:** The review will include team members who directly contribute to the patient's care plan as their input is necessary for a comprehensive evaluation of the patient's care and progress, e.g., representatives from the clinical team, relevant leadership and other relevant departments (e.g., health information, pharmacy, IPAC).
    - **Data Collection and Review:** Reviews will involve data collection using the Quality of Care Review Meeting Template (51-A-290-XX), interviews with staff and patients, chart reviews, and analysis of relevant documentation.
    - **Confidential and Targeted Discussion:** All information gathered during the review will be confidential, and only authorized personnel will have access to sensitive data. Restricted access to meeting fosters a secure environment where challenges can be openly addressed and improvements in care delivery are proposed.

4. **Documentation and Reporting**:
    - All findings from the quality care review shall be documented in a formal report (Appendix A) The report will include identified areas of concern, recommendations for improvement, and a timeline for corrective action if applicable.
    - A summary of the findings will be shared with the management team and relevant stakeholders, ensuring that all actionable items are addressed promptly.

- Recommendations for improvement will be submitted to the Board Quality committee and Quality and Safety Advisory committee to track progress, promote accountability and ensure patient safety care standards are met.
- Documentation of the review process and final report will be securely stored and protected in accordance with QCIPA.

5. **Protecting Quality Care Information**:
   - All quality care review data, including patient records, staff information, and internal reports, will be handled in compliance with confidentiality protocols.
   - Access to review information will be restricted to authorized personnel only.
   - Electronic records will be protected through encryption, password access, and other cybersecurity measures.

6. **Follow-up and Continuous Improvement**:
   - Once corrective actions have been implemented, follow-up reviews will be scheduled to assess the effectiveness of the changes and ensure continuous improvement in care quality.
   - Any recurring issues or trends identified during subsequent reviews will trigger further investigation and potential policy adjustments.

DEFINITIONS:

Quality of Care: The degree to which healthcare services provided to individuals increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Care Review: A structured process used to assess and evaluate the performance of healthcare services, including safety, clinical outcomes, patient experience, and resource utilization.

Quality of Care Information Protection Act (QOCIPA): A legal framework designed to protect sensitive information generated during quality care reviews to ensure patient privacy, organizational integrity, and compliance with regulatory standards.

Sensitive Information: Any data or documentation relating to patient care, staff performance, or organizational operations that is considered confidential and requires protection under QCIPA, e.g., information produced during a quality review such as opinions, audit results, interview reports, evaluations, and root cause analyses.

Sentinel /Serious/Adverse event: any unexpected occurrence or near miss occurrence involving death, serious physical or psychological injury, or risk thereof. Specific sentinel events include, but are not limited to:

- **Patient Deaths**:
  - Unanticipated deaths related to healthcare interventions or errors.

    - Deaths from complications of medical procedures or treatments.
- **Serious Physical or Psychological Injury**:
    - Permanent or significant disability.
    - Injury resulting from a healthcare error, including falls, infections, or surgical complications.
    - Events leading to long-term mental health issues or trauma.
- **Surgical or Procedural Errors**:
    - Wrong-site, wrong-procedure, or wrong-patient surgeries.
    - Retained surgical items (e.g., sponges, instruments).
    - Anesthesia-related errors or complications.
- **Medication Errors**:
    - Incorrect drug administration, including wrong dosage, wrong medication, or incorrect route.
    - Adverse drug reactions that result in severe harm or death.
- **Infection Control Failures**:
    - Outbreaks of infections that could have been prevented through proper hygiene or protocols.
    - Infection due to improper sterilization of medical equipment or lack of infection prevention measures.
- **Blood Transfusion Errors**:
    - Incorrect blood transfusions or mismatched blood types leading to severe reactions or death.
- **Elopement or Patient Absconding**:
    - Patients leaving care settings (especially in psychiatric or emergency settings) where their safety and well-being are at risk.
- **Falls Resulting in Serious Injury**:
    - Falls in hospital or care settings leading to fractures, neurological damage, or other severe injuries.
- **Loss of Organ Function**:
    - Instances where vital organ function is lost or severely compromised due to medical errors or negligence.
- **Restraint-Related Events**:
    - Patient injury or death related to the use of restraints, either physical or chemical.
- **Delayed Diagnosis or Misdiagnosis**:
    - Events where a delay or error in diagnosis results in significant harm or death.

CROSS-REFERENCED POLICIES:

Policy Number	Policy Name
COR.11.06.0.24	Incident Reporting

ASSOCIATED FORMS:

Form Number	Form Name
51-A-290-XX	Quality of Care Review Meeting Template

REFERENCES:

1. Canada Health Act (CHA), RSC 1985, c. C-6 https://laws-lois.justice.gc.ca/eng/acts/C-6
2. Personal Health Information Protection Act (PHIPA), 2004, S.O. 2004, c. 3 (Ontario) https://www.ontario.ca/laws/statute/04p03
3. PIPEDA – Personal Information Protection and Electronic Documents Act, SC 2000, c. 5. https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/the-personal-information-protection-and-electronic-documents-act-pipeda/
4. Canadian Patient Safety Institute (CPSI) – Patient Safety and Quality Improvement Framework https://www.healthcareexcellence.ca/media/e3dkkwos/cpsi-10001-cqps-framework-english_fa_online-final-ua.pdf
5. The Accreditation Canada – Quality Standards https://accreditation.ca/standards/
6. The Office of the Privacy Commissioner of Canada (OPC) https://www.ipc.on.ca/en

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☐ Board Committee – Quality & Risk Management ☐ Senior Leadership Team

☒ Other *(please specify):* Quality and Safety Advisory Committee

Date Prepared: February 5, 2025 Meeting Date Prepared for: February 12, 2025

Subject: Quality Improvement Plan (QIP) Results- Q3

Prepared by: Rachel Romany- Vice President Clinical Services, Quality, Chief Nursing Executive

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To review the results of the Quality Improvement Plan for Q3
- Discuss contributing factors and mitigation strategies for improvement

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

- In June 2010, the Ontario Government passed the Excellent Care for All Act. This legislation was designed to put patients first with a focus on the health care sector's accountability for delivering high quality patient care.
- One of the ways this accountability is being made transparent is through the requirement that all hospitals create and make public their annual Quality Improvement Plan (QIP).
- A QIP is a formal, documented set of Quality commitments aligned with system and provincial priorities that a health care organization makes yearly to its patients, staff, and community to improve quality through focused targets and actions.
- Each year, four themes are chosen and targets are established for each indicator to be achieved.
- The 2024/25 QIP themes, quality dimension and six (6) indicators are as follows:
    - Access & Flow- Timely transitions- % of patients who visited the ED and left without being seen by the physician
    - Access & Flow- Timely transitions- 90th percentile ED wait time to inpatient bed
    - Equity-Equitable - % of executive and management staff who have completed relevant inclusion, diversity, equity and anti-racism (IDEA) education.
    - Experience- Patient-centered- % respondents who respond positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?
    - Safety- Safe- Rate of workplace physical violence incidents resulting in lost time injury
    - Safety- Safe- Number of reported near misses related to controlled substances within the organization

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.

Our QIP for Q3 has yielded the following results:

Access & Flow- Timely transitions- % of patients who visited the ED and left without being seen by the physician

THEME	DIMENSION	METRIC	YEAR END FISCAL 2023	TARGET PERFORMANCE	Apr-24	May-24	Jun-24	Q1	Jul-24	Aug-24	Sep-24	Q2	Oct-24	Nov-24	Dec-24	Q3	Jan-25	Feb-25	Mar-25	Q4	YTD
Access & Flow	Timely	Percent of patients who visited the ED and left without being seen by a physician	8.8%	7.7%	9.8%	12.4%	10.0%	10.8%	9.3%	6.8%	7.4%	7.8%	7.8%	7.6%	5.7%	7.1%					8.5%

- Q3 ended with 7.1%, achieving the target of staying below 7.7%..
- **Strategy:** Current ED initiative to have additional physician coverage (4 hours, MWSun) during ED visit peak hours to support faster access for low-acuity ED visits, improve patient flow, reduce the number of patients leaving without being seen, and improve Physician Initial Assessment times.

Access & Flow- Timely transitions- 90th percentile ED wait time to inpatient bed

THEME	DIMENSION	METRIC	YEAR END FISCAL 2023	TARGET PERFORMANCE	Apr-24	May-24	Jun-24	Q1	Jul-24	Aug-24	Sep-24	Q2	Oct-24	Nov-24	Dec-24	Q3	Jan-25	Feb-25	Mar-25	Q4	YTD
Access & Flow	Timely	90th percentile emergency department wait time to inpatient bed	5.8	6.0	2.8	3.1	3.2	3.0	3.7	3.1	3.5	3.4	2.9	3.3	5.0	3.7					3.1

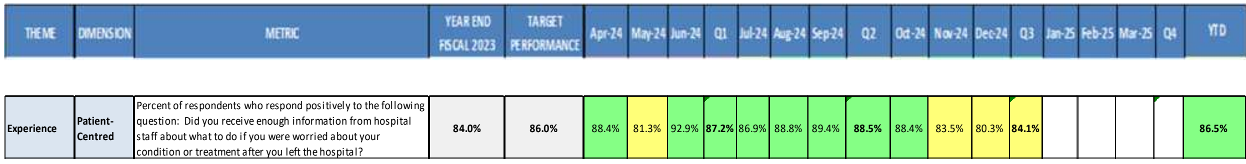
- Q3 ended with 3.7 hours, which is positively below the target of 6 hours.
- **Strategy:** continuous improvement processes such as clear communication protocols between ED and inpatient team to ensure seamless transitions and quick responses.

Equity-Equitable - % of executive and management staff who have completed relevant inclusion, diversity, equity and anti-racism (IDEA) education.

THEME	DIMENSION	METRIC	YEAR END FISCAL 2023	TARGET PERFORMANCE	Apr-24	May-24	Jun-24	Q1	Jul-24	Aug-24	Sep-24	Q2	Oct-24	Nov-24	Dec-24	Q3	Jan-25	Feb-25	Mar-25	Q4	YTD
Equity	Equitable	Percent of executive and management staff who have completed relevant inclusion, diversity, equity and accessibility (IDEA) education.	0.0%	100.0%	0.0%	35.7%	0.0%	11.9%	0.0%	0.0%	0.0%	0.0%	92.9%	83.3%	90.6%	88.1%					55.2%

- Q3 ended with 88.1%, aligning to target of 100% at Q4.
- **Strategy:** IDEA micro-learnings curriculum is completed by the leadership team, and the Board of Directors. Monthly leadership meetings include a discussion on the module, promoting collaboration and the sharing of insights. This initiative enhances understanding and encourages active participation and supports ongoing learning within the organization.

Experience- Patient-centered- % respondents who respond positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?



THEME	DIMENSION	METRIC	YEAR END FISCAL 2023	TARGET PERFORMANCE	Apr-24	May-24	Jun-24	Q1	Jul-24	Aug-24	Sep-24	Q2	Oct-24	Nov-24	Dec-24	Q3	Jan-25	Feb-25	Mar-25	Q4	YTD
Experience	Patient-Centred	Percent of respondents who respond positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	84.0%	86.0%	88.4%	81.3%	92.9%	87.2%	86.9%	88.8%	89.4%	88.5%	88.4%	83.5%	80.3%	84.1%					86.5%

- Q3 ended with 84.1%, which is slightly below the target of 86%.
- **Strategy:** Consistently ensure that discharge instructions are clear and thorough, emphasizing patient understanding.

Safety- Safe- Rate of workplace physical violence incidents resulting in lost time injury

THEME	DIMENSION	METRIC	YEAR END FISCAL 2023	TARGET PERFORMANCE	Apr-24	May-24	Jun-24	Q1	Jul-24	Aug-24	Sep-24	Q2	Oct-24	Nov-24	Dec-24	Q3	Jan-25	Feb-25	Mar-25	Q4	YTD
Safety	Safe	Rate of workplace physical violence incidents resulting in lost time injury	0.6%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%					0.0%

- Q3 ended at 0%, which is favorably below our target of 0.5%.
- Strategy : Emphasis on proactive approaches to avoid or reduce violent incidents, creating a safer and more supportive environment for both patients and staff.

Safety- Safe- Number of reported near misses related to controlled substances within the organization

THEME	DIMENSION	METRIC	YEAR END FISCAL 2023	TARGET PERFORMANCE	Apr-24	May-24	Jun-24	Q1	Jul-24	Aug-24	Sep-24	Q2	Oct-24	Nov-24	Dec-24	Q3	Jan-25	Feb-25	Mar-25	Q4	YTD
Safety	Safe	Number of reported near misses related to controlled substances within the organization.	20	12	25	29	23	26	16	25	18	20	26	26	21	24					209

- Q3 ended at 24 incidents, which did not meet the target of 12 reported incidents.
- Strategy:
  - Continuous evaluation of dispensing and documentation processes, including narcotic counts, investigations of potential losses, and gathering feedback from staff.
  - Pharmacy providing constructive feedback and additional training where necessary.
  - Diversion prevention education included in the orientation session for new employees.

Summary

- The Quality Improvement Plan 2024-25 highlights our achievements in meeting most Q3 targets and emphasizes that ongoing teamwork and collaboration are essential for our continuous improvement as we tackle areas of opportunities.

Quality Improvement Plan (QIP)

Fiscal 2024/25

Print

THEME	DIMENSION	METRIC	YEAR END FISCAL 2023	TARGET PERFORMANCE	Apr-24	May-24	Jun-24	Q1	Jul-24	Aug-24	Sep-24	Q2	Oct-24	Nov-24	Dec-24	Q3	Jan-25	Feb-25	Mar-25	Q4	YTD
Access & Flow	Timely	Percent of patients who visited the ED and left without being seen by a physician	8.8%	7.7%	9.8%	12.4%	10.0%	**10.8%**	9.3%	6.8%	7.4%	**7.8%**	7.8%	7.6%	5.7%	**7.1%**					**8.5%**
Access & Flow	Timely	90th percentile emergency department wait time to inpatient bed	5.8	6.0	2.8	3.1	3.2	**3.0**	3.7	3.1	3.5	**3.4**	2.9	3.3	5.0	**3.7**					**3.1**
Equity	Equitable	Percent of executive and management staff who have completed relevant inclusion, diversity, equity and accessibility (IDEA) education.	0.0%	100.0%	0.0%	35.7%	0.0%	11.9%	0.0%	0.0%	0.0%	0.0%	92.9%	83.3%	90.6%	88.1%					**55.2%**
Experience	Patient-Centred	Percent of respondents who respond positively to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	84.0%	86.0%	88.4%	81.3%	92.9%	**87.2%**	86.9%	88.8%	89.4%	**88.5%**	88.4%	83.5%	80.3%	**84.1%**					**86.5%**
Safety	Safe	Rate of workplace physical violence incidents resulting in lost time injury	0.6%	0.5%	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%	**0.0%**					**0.0%**
Safety	Safe	Number of reported near misses related to controlled substances within the organization.	20	12	25	29	23	**26**	16	25	18	**20**	26	26	21	**24**					**209**

Metric underperforming target by more than 25%

Metric within 25% of target

Metric equal or outperforming target

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared:	Jan 23, 2025	Meeting Date Prepared for:	February 12, 2025
Subject:	Quality Improvement Plan (QIP) 25/26		
Prepared by:	Rachel Romany- Vice President Clinical Services, Quality, Chief Nursing Executive		

☒ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To seek approval for the 2025-2026 Quality Improvement Plan (QIP) that is to be submitted to Ontario Health.

RECOMMENDATION / MOTION

- That the Quality & Patient Safety Committee recommend to the Board of Directors the approval of the Quality Improvement Plan for 2025-26 and the QIP narrative as presented.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

- Quality and Safety Advisory – Dec 19, 2024, January 22, 2025
- Senior Leadership Team- Jan 28, 2025
- MAC – February 4, 2025
- Board Quality- February 12, 2025
- PFAC – February 19, 2024
- Board of Directors- February 27, 2025
- Submission due to OH on March 31, 2025

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Continued focus on four province-wide priority issues: (1) Access and flow, (2) Equity, (3) Experience, and (4) Safety which means priority and optional indicators are the same as those of last year.
- Indicators for the hospital sector are being adjusted to align with new/existing programs and partners such as the Emergency Department Return Visit Quality Program (EDRVQP), Emergency department Pay-for-Results program (P4R) and Delirium Aware Safer Healthcare campaign (DASH).
- See attached 2025/26 Quality Improvement Plan Program: Indicator Matrix for review of indicators.
- To ensure alignment with the strategic and operating plans, as well as Accreditation Standards, specific indicators were selected to be incorporated into the Quality Improvement Plan.
- These indicators will serve as key focus areas for the organization in 2025-2026, with the goal of fostering continuous improvement and achieving better outcomes for our patients

Draft 2025-2026 QIP

		Quality Improvement Plan 2025-2026				
THEME	**QUALITY DIMENSION**	**MEASURE/INDICATOR**	**UNIT/POPULATION**	**SOURCE/PERIOD**	**CURRENT PERFORMANCE**	**TARGET PERFORMANCE**
Access & Flow	**Timely**	Percent of patients who visited the ED and left without being seen by a physician	% / ED patients	ERNI scorecard April 1- December 2024 (Q1-Q3)	9%	8%
Access & Flow	**Timely**	90th percentile emergency department wait time to physician initial assessment (PIA)	Hours / ED patients	ERNI scorecard April 1- December 2024 (Q1-Q3)	4.90	4.6
Equity	**Equitable**	Percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accesibility (IDEA) education.	% / applicable Staff	Local data collection/most recent consecutive 12-month period	n/a	25%
Experience	**Patient-Centred**	Percentage of respondents who respond positively to the following question: *Were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?*	% / Survey respondents	Qualtrics Survey April 1- December 2024 (Q1-Q3)	87%	89%
Safety	**Safe**	Rate of workplace physical violence incidents resulting in lost time injury	% / Staff	Local data collection/most recent consecutive 12-month period	0%	0%
Safety	**Safe**	Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)	Number	Local data collection 2023-24	12	10

IMPLEMENTATION & COMMUNICATION PLAN

Consider how the recommendation will be rolled-out and communicated to all key stakeholders.

- Communication at each committee as above.
- Quality and Safety Advisory committee will be accountable to track/trend and implement strategies to achieve targets.

SUPPORTING DOCUMENTS/ATTACHMENTS

- Quality Improvement Plan (QIP) Narrative for Healthcare Organizations in Ontario

Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

2/27/2025

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Hôpital Glengarry Memorial Hospital (HGMH) is a designated bilingual (French, English) hospital in Alexandria, Ontario. HGMH provides acute care, 24-hour emergency services, outpatient services and sub-acute rehabilitation services to residents in our local Eastern Ontario community.

HGMH is an organization committed to the **Mission** of *delivering outstanding care for our communities*, which fuels the **Vision** of *providing your care, your way, with seamless integration, innovation, and equitable access for our communities.*

HGMH team continues to advance the organization forward with four strategic priorities:

- **Quality and Safety:** enrich the patient experience through quality, safe care that welcomes patients and families as partners in care.
- **People and Culture:** improve engagement by investing in the organization's people and empower a caring and positive culture for all.
- **Integration and Standardization**: deliver standardized quality care in a cost-effective way through collaboration and integration opportunities.
- **Future Planning**: invest in the sustainability of equipment and infrastructure to support safe, quality care.

HGMH is pleased to present its 2025-26 Quality Improvement Plan (QIP). It is one component of the overall organizational approach to quality and safety, with initiatives selected that are consistent with the Strategic Plan, Patient Safety Plan, Hospital Service Accountability Agreement, Accreditation standards, and informs our operating plan. In addition, input on this plan is sought from the Quality and Safety Advisory Committee, and from the Board of Directors, the Leadership Team, the Medical Advisory Committee, and the Patient and Family Advisory Committee.
HGMH is committed to focus on indicators that Ontario Health has identified as priorities for hospitals.

Quality Improvement Plan 2025-2026

THEME	QUALITY DIMENSION	MEASURE/INDICATOR	UNIT/POPULATION	SOURCE/PERIOD	CURRENT PERFORMANCE	TARGET PERFORMANCE
Access & Flow	Timely	Percent of patients who visited the ED and left without being seen by a physician	% / ED patients	ERNI scorecard April 1- December 2024 (Q1-Q3)	9%	8%
Access & Flow	Timely	90th percentile emergency department wait time to physician initial assessment (PIA)	Hours / ED patients	ERNI scorecard April 1- December 2024 (Q1-Q3)	4.90	4.6
Equity	Equitable	Percentage of Full-time and Part-time staff who have completed relevant inclusion, diversity, equity and accesibility (IDEA) education.	% / applicable Staff	Local data collection/most recent consecutive 12-month period	n/a	25%
Experience	Patient-Centred	Percentage of respondents who respond positively to the following question: *Were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?*	% / Survey respondents	Qualtrics Survey April 1- December 2024 (Q1-Q3)	87%	89%
Safety	Safe	Rate of workplace physical violence incidents resulting in lost time injury	% / Staff	Local data collection/most recent consecutive 12-month period	0%	0%
Safety	Safe	Number of medication errors that reached the patient due to wrong drug/dose/patient (incident severity levels 2-5)	Number	Local data collection 2023-24	12	10

Access and Flow

Maximizing hospital capacity, ensuring timely access to care, and optimizing patient flow contribute to better patient outcomes and enhance the overall patient experience.
At HGMH, we are implementing several strategies to address these areas, including:

- **Enhanced Emergency Department (ED) Capacity**: A strategic initiative aimed at reducing the number of patients who leave the ED without being seen by a physician, as well as decreasing wait times for the physician's initial assessment (PIA). This is achieved by adding an additional ED physician during peak hours and on specific days of high ED activity.
- **Multidisciplinary Rounds**: Daily rounds involving healthcare professionals from various disciplines to efficiently coordinate care, assess patient statuses, facilitate and expedite discharges, and ensure a collaborative team approach to treatment.
- **Bedboard Tool**: The Daily Bedboard Tool is used to optimize bed utilization, reduce wait times, and ensure that patients receive appropriate care based on their needs and the resources available.
- **Regional Bed Planning**: Daily coordination of bed planning across the region to ensure the most efficient use of available beds and resources.
- **Collaboration with Great River Ontario Health Team (GROHT)**: Active partnerships with GROHT and local community agencies to ensure patients have timely and adequate access to care.
- **Ongoing Partnerships with Ontario Health and The Ottawa Hospital (TOH)**: Continued collaboration through the ED Peer-to-Peer Program and the TOH Virtual Critical Care initiative to enhance care coordination and access to specialized services.

Equity and Indigenous Health

HGMH is a designated agency under the French Language Services Act (FLSA). We are committed to providing our French-speaking population with access in French to the full range of quality care and services being offered. This includes access to French-speaking health care professionals as well as providing all educational materials in both official languages.
As part of our commitment to health equity, HGMH is actively engaged in several initiatives:

- **IDEA Committee**: The Inclusion, Diversity, Equity, and Anti-Racism (IDEA) Committee has been established to promote diverse and inclusive care. The committee oversees the development and implementation of a framework focused on ensuring inclusiveness, diversity, equity, and anti-racism within the organization.
- **IDEA Framework**: This framework guides our practices and policies to ensure they are aligned with the principles of fairness and equitable opportunity for all.
- **Partnerships for Culturally Safe Care**: We are building formal and informal partnerships with external agencies to provide culturally safe care for Indigenous patients and their families. This includes collaborating with individuals with lived experience to create training opportunities for staff.

- **Patient Satisfaction Surveys**: We have incorporated diversity-related questions into our patient satisfaction surveys to help us better understand the needs of our diverse population. This data will inform the development of current and future care models.
- **Indigenous Healthcare Training**: Collaborating with a Diversity, Equity, and Inclusion (DEI) training provider to offer tailored DEI learnings for our leadership team and staff, empowering our teams with the knowledge, strategies, and interventions necessary to ethically and effectively meet the needs of diverse clients.
- **On-Demand Medical Translation**: HGMH has implemented on-demand medical translation services, covering over 240 languages and dialects, including American Sign Language. This service ensures that language barriers do not hinder access to quality care.

Patient/Client/Resident Experience

HGMH values a patient and family-centered approach to health care. Our patients and their families play a vital role in improving the patient experience at our hospital. The Patient and Family Advisory Committee provides a way for staff and leadership to connect with patients and family members and seek advice on how to continue to improve how care is delivered. HGMH prioritizes observations, compliments and feedback from patients, families/caregivers, and input from Patient Satisfaction surveys. Ongoing initiatives have been introduced to recognize the importance of having a loved one or support person present during a patient's hospital stay for healing and recovery, in alignment with guidelines developed by the Registered Nurses Association of Ontario (RNAO). These initiatives include:

- **Essential Care Partner Program**: presence of a support person is essential to the safety and well-being of a patient during their hospital stay and is a valued member of the care team.
- **Hospital Elder Life Program**: with the support of trained team of volunteers, this patient care program provides support to older patients and conducts activities that help keep patient mentally and physically active and help prevent delirium and reduce the risk of functional decline.
- **Purposeful Hourly Rounding Program:** proactively and promptly identify any emerging concerns, fostering trust by ensuring patients feel heard and supported throughout their hospital stay.
- **Supportive Communication for Adults with Aphasia (SCA):** trains staff and caregivers on how to assist patients with aphasia, a language impairment that affects an individual's ability to express themselves or understand spoken and written language.

Provider Experience

HGMH is committed to providing a positive and caring culture for all staff. Prioritization of staff and physician well-being and support of a better work-life balance enable them to provide the best possible care to our patients. These initiatives include:

- **Online health and wellness resources**: 24/7 access to Employee Assistance Program (EAP)
- **Strategic Human Resources Plan**: focus on optimizing workforce, recruitment and retention of top talent, positive work environment and employee engagement
- **Social Club and Social Integration Committee**
- **Care Champion Program**: platform for patients and families to express their gratitude for exceptional patient experiences.
- **Employee Satisfaction and Engagement Survey**
- **Staff Town Halls and Department meetings**: addressing issues and conveying concerns
- **Roundtable conversations with the CEO and CEO quarterly VLOGs (Video Blogs)**
- **Weekly Clinical Leadership newsletter & Biweekly Corporate Newsletter**
- Quality Board Huddles
- Monthly Departmental Inspections
- Physician newsletter update
- Monthly Occupational Health and Safety Talks
- Board Award of Excellence
- Mrs. Oma Award
- Annual Team Award
- Annual Dr. Govan Award

Safety

HGMH, as a designated RNAO Best Practice Spotlight Organization (BPSO), enhances patient safety through the integration of evidence-based best practice guidelines (BPG) and standardized care. By prioritizing continuous quality improvement, staff education, and patient-centered care, we reduce errors and ensure consistent, high-quality care. Collaboration among interprofessional teams and empowering patients to actively engage in their care further strengthens safety and decision-making. RNAO BPGs that our team worked on include: Preventing Falls and Reducing Injury from Falls, Alternative Approaches to the Use of Restraints, Delirium, Dementia, and Depression in Older Adults, Person & Family Centered Care, and Care Transitions.

Our Patient Safety Plan centers on patient safety, accountability, and reporting adverse events and near misses. The incident reporting system (RIMs) enables staff to report safety issues, with leadership and the Board reviewing trends impacting patient outcomes. The Board Quality and Quality and Safety Advisory Committees monitor incidents and use patient narratives to improve quality and patient-centered care.

Palliative Care

Our dedication to providing high-quality palliative care is in alignment with the RNAO Best Practice Guidelines (BPG) for End-of-Life Care and Palliative Care with the corresponding action measures in the following areas:

- Early initiation of palliative care
- Ongoing staff education and training
- Utilization of assessment tools for comprehensive symptom and spiritual care evaluation
- Engagement and education of patients and care partners regarding early palliative care integration and goals-of-care discussions
- Psychological and social support for patients and families navigating end-of-life decisions, the grieving process, and care coordination and transitions
- Mental and emotional wellness resources for staff to ensure sustained delivery of high-quality palliative care

Population Health Approach

HGMH plays a vital role in improving population health outcomes and help reduce health disparities and inequities within the community with approaches such as:

- Preventative Care programs- to promote early disease detection and prevention with screenings and education.
- Chronic Disease management- utilization of coordinated care plans for heart disease led regionally by the University of Ottawa Heart Institute with provision of Cardiac Rehabilitation services and standardized discharge planning.
- Community partnerships- collaboration with public health agencies, primary care, local organizations, and social services to help address social determinants of health and improve continuity of care and patient outcomes.
- Telehealth and remote monitoring device (Holter monitor) to expand access to care and provide proactive and preventative patient care.
- Rehabilitation beds to address increasing general, post stroke, and geriatric rehabilitation access needs in the region.

Executive Compensation

The Excellent Care for All Act (ECFAA, 2010) mandates that executive compensation be tied to the Quality Improvement Plan (QIP). The Executive Compensation Philosophy aims to establish competitive pay based on market standards while fostering organizational performance and behaviors that achieve defined objectives.

HGMH is dedicated to rewarding the CEO, COS, and Executive Team for their strategic leadership with an incentive plan that drives engagement, results orientation, and commitment to achieving key goals.

The plan focuses on quality performance and promotes a team-oriented approach to organizational success, ensuring that compensation reflects their contributions to the organization's overall goals.

Contact Information

Rachel Romany
Vice-President Clinical Services, Quality & Chief Nursing Executive
613-525-2222 ext. 4110

Sign-off

I have reviewed and approved our organization's Quality Improvement Plan on February 27, 2025.

Stuart Robertson, Board Chair ________________________________

Carol Larocque, Board Quality Committee Chair ________________________________

Robert Alldred-Hughes, Chief Executive Officer ________________________________

Rachel Romany, Other leadership as appropriate ________________________________

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: February 5, 2025 Meeting Date Prepared for: Februayr 12, 2025

Subject: Board Quality and Safety Scorecard Results

Prepared by: Rachel Romany - Vice President Clinical Services, Quality, Chief Nursing Executive

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To review the Q3 results of the Quality and Safety Scorecard 2024-25
- Discuss contributing factors and mitigation strategies for improvement

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ No ☐ Yes, please specify:

SITUATION & BACKGROUND

A brief description of the background to the issue.

- The 2024/25 dashboard indicators are based on quality themes such as:
  - Timely and Efficient Transitions
    - 90th percentile ED wait time to inpatient bed
  - Service Excellence
    - Patients respond positively to the following question: Did patients feel they received adequate information about their health and their care at discharge?
    - Number of complaints and compliments received
  - Safety and Effective Care
    - Rate of delirium onset during hospitalization
    - Fall Rate, Falls with injury
    - Violent Incident Rate, # of violent incidents that have a multidisciplinary action plan
    - Medication errors
    - Pressure Injury Development during inpatient stay
    - Hand Hygiene Compliance Rate for Moments 1 and 4
    - Hospital acquired infections (HAI) rates - C.Difficile, VRE, MRSA
  - Equity
    - Translation services usage- Language Line services

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.

Achieving Targets:

Celebrating achievements and milestones with these scorecard results, help maintain staff engagement and encourage ongoing progress toward our quality care goals.

Area of opportunities:

Hand Hygiene compliance rate (Moment 1)

Q3 result is 73.7%, which did not meet our target of 92%.

- Strategy:
  - Ongoing reminders to staff about key hand hygiene moments and fostering a culture of accountability through regular monitoring and feedback.

SUMMARY

Focusing on quality indicators is essential for maintaining top care standards and protecting patient well-being. This requires ongoing performance reviews and efforts to address any areas needing improvement.

THEME	METRIC	MEASUREMENT	YEAR END FISCAL 2023	TARGET PERFORMANCE	Q1	Q2	Q3	Q4	YTD	AIM	Visualization
1.Timely & Efficient Transitions											
	90th percentile emergency department wait time to inpatient bed	hours	5.8	6.0	3.0	3.4	3.7		3.1	Below	
2. Service Excellence											
	Percentage of respondents answering yes to the question "did you participate in your plan of care?"	% of those who answered Positively/total surveys	78.0%	80.0%	95.4%	96.3%	92.1%		94.6%	Above	
3. Safe & Effective Care											
	Fall Rate	# of incidents per 1000 patient days	13	12	12.5	19.9	9.8		13.8	Below	
	Falls with Injury (any fall requiring intervention or treatment)	# of incidents per 1000 patient days	2.00	2.00	3.89	0.01	0.00		0.00	Below	
	Incidents of Physical Violence	Actual number	84	75	5	0	5		10	Below	
	Medication Errors (reaching the patient secondary to wrong drug/dose/patient)	Actual number	59	52	7	15	11		33	Below	
	Pressure injury development rate (stage 2,3,4) during inpatient stays	Actual number	0	0	0	1	0		1	Below	
	Hand hygiene compliance rate (Moment 1)	# compliant activities / # of indicated activities	79.0%	92.0%	70.0%	83.0%	73.7%		75.6%	Above	
	Hand hygiene compliance rate (Moment 4)	# compliant activities / # of indicated activities	88.0%	92.0%	83.7%	97.3%	96.7%		92.6%	Above	
	C. difficile rate	# of incidents per 1000 patient days	0.30	0.00	0.86	0.44	0.38		0.55	Below	
	VRE Rate	# of incidents per 1000 patient days	0.00	0.00	0.00	0.00	0.00		0.00	Below	
	MRSA Rate	# of incidents per 1000 patient days	0.4	0.00	0.86	0.00	0.38		0.41	Below	
4. Equity											
	Translation Services Usage	Number of minutes		50	4	118	49		171	Above	

Metric underperforming target by more than 25%

Metric within 25% of target

Metric equal or outperforming target

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: February 5, 2025 Meeting Date Prepared for: February 12, 2025

Subject: Patient Satisfaction Surveys Q3

Prepared by: Rachel Romany- VP Clinical Services, Quality, Chief Nursing Executive

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- Present a revised layout of patient satisfaction survey results for Emergency Department, Outpatient, and Inpatient/Rehab services to improve clarity and track monthly trends.
- Enable better monitoring of consistency and reliability in patient care over time.
- Highlight top satisfaction indicators and identify areas for improvement to guide targeted service enhancements.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

- Quality and Safety Advisory Committee
- Patient & Family Advisory Committee

ANALYSIS

EMERGENCY DEPARTMENT

Quarterly Dashboard 1,284

	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Care Rating	7.7	8.3	8.3	8.3
I did not have a long wait	52%	62%	58%	53%
During the visit, were you told the reason for the long wait?-1 to 3	24%	31%	25%	24%
Do you feel that there was good communication about your care between doctors?-1 to 4	95%	96%	96%	96%
How often did care providers treat you with courtesy and respect?	99%	99%	99%	100%
How often did care providers explain things in a way you could understand?	96%	98%	98%	97%
Did you get the emotional support you needed to help you with any anxieties?	86%	89%	91%	86%
Did care providers do everything they could to ease your discomfort?	86%	88%	90%	87%
Did you participate in your plan of care?-1 to 3	89%	93%	92%	95%

- Note: Q4 2025 column is the YTD average result for the indicator.

Explanation of indicators and desired target (AIM):

THEME	AIM	Type of indication	Notes
Care Rating	Above	Patient Centered- Care	Average of the ratings given of the overall patient's
I did not have a long wait	Above	Access and Flow	Indicates if the patient had a long wait- the greater the percentage indicates a subjective feeling that patient did not wait long
During the visit, were you told the reason for the long wait?	Above	Access and Flow	Indication that if the patient had a long wait, there was a communication as to why there is a long wait
Do you feel there was good communication about your care between	Above	Patient Safety	Patient safety indication where the patient felt that the providers are **working together** to provide care
How often did care providers treat you with	Above	Patient Centered- Care	Indication on how the patient was treated while in
How often did care providers explain things in a way you could understand?	Above	Patient Centered- Care	Indicates if there was communication on the diagnosis and treatment of the patient in a way that the patient could understand (e.g. not using
Did you get the emotional support you needed to help you with any anxieties?	Above	Patient Centered- Care	Indication that the hospital is going the "extra mile" to make the patient feel comfortable
Did care providers do everything they could to ease your discomfort?	Above	Patient Centered- Care	Indication that the hospital is going the "extra mile" to make the patient feel comfortable
Did you participate in your plan of care?	Above	Patient Centered- Care	Indicator that signifies that there was the patient's active involvement during the encounter.

Top Satisfaction Indicators:

- Care rating out of scale of 10 = 8.3
- Communication about patient care between doctors = 96%
- Explanation of things that patients can understand = 98%
- Treated patients with courtesy and respect = 99%
- Patient participated in their plan of care = 95%

Improvement Opportunities

- 42% of patients felt they had a long wait
- 25% of patients were not given a reason for the wait

Strategies

- Staffing- continue to ensure adequate staffing during busy times to decrease wait times, i.e. additional physician to support increased activity and workload
- Communication- continue to update patients on expected wait times and delays to manage expectations and reduce frustration even if the wait is longer than anticipated.

INPATIENT REHAB UNIT

Monthly Dashboard

	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Care Rating	9.8	8.8	9.8	8.8
Do you feel that there was good communication about your care between healthcare providers?	100%	100%	100%	100%
Did you receive enough information from hospital staff?	100%	100%	100%	100%
Involvement of Plan of Care	60%	53%	52%	57%
Friends/ family involvement	80%	83%	100%	100%

Explanation of indicators and desired target (AIM):

THEME	AIM	Type of indication	Notes
Care Rating	Above	Patient Centered- Care	Average of the ratings given of the overall
Do you feel that there was good communication about your care	Above	Patient Safety	Patient safety indication where the patient felt that the providers are **working together** to
Did you receive enough information	Above	Patient Centered- Care	Indication that the patient had instructions
Involvement of Plan of Care	Above	Patient Centered- Care	Indicator that signifies that there was the patient's active involvement during the
Friends/ family involvement	Above	Patient Centered- Care	Indicator that signifies that there was an active family/friend involvement in the rehabilitation

Top Indicators

- Care rating out of scale of 10 = 9.8
- Communication about patient care between healthcare providers = 100%
- Received enough information from hospital staff = 100%
- Friends/family involvement in the patient's rehabilitation journey = 100%

Improvement Opportunity

- Patient's active involvement during the rehabilitation journey = 57%

Strategies

- Patient support- continue to provide the necessary support and understanding for patients who may have limited ability to actively engage, e.g. offer information in a variety of formats- verbal, written, visual.
- Patient engagement and goal setting- continue to encourage patient involvement at a pace that aligns with their current abilities, while setting achievable milestones to help the patient maintain a sense of accomplishment and motivation.

__OUTPATIENT DEPARTMENT__

Monthly Dashboard 188

	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Overall Care rating	9.2	9.5	9.7	8.3
If you had a long wait, were you told the reason why	18%	21%	23%	33%
Got the appointment in 6 weeks or less	80%	72%	79%	100%
Appointment Wait Time <15 mins	88%	97%	95%	75%
Did you feel like the healthcare providers worked together?	95%	100%	97%	75%
Did you feel you were treated with respect and dignity?	97%	100%	100%	100%
Were you involved as much as you wanted to be?	96%	96%	100%	50%

Explanation of indicators and desired target (AIM):

THEME	AIM	Type of indication	Notes
Care Rating	Above	Patient Centered- Care	Average of the ratings given of the overall
If you had a long wait, were you told the reason why?	Above	Access and Flow	Indication that if the patient had a long wait, there was a communication as to why there is a long wait time.
Got the appointment in 6 weeks of less	Above	Access and Flow	Indication if the patient got an appointment within 6 weeks from referral
Appointment wait time <15 minutes	Above	Access and Flow	Indication if the patient waited for less than 15 minutes when they checked-in for the
Did you feel like the healthcare providers worked together?	Above	Safety	Patient safety indication where the patient felt that the providers are **working together** to
Did you feel you were treated with	Above	Patient Centered- Care	Indication that the patient was treated well
Were you involved as much as you wanted to be?	Above	Patient Centered- Care	Indicator that signifies that there was the patient's active involvement during the

Top Indicators

- Care rating out of scale of 10 = 8.3
- Patient appointment's wait time is less than 15 minutes = 95%
- Patients felt the healthcare providers worked together = 97%
- Patients were treated with respect and dignity = 100%
- Patients felt they were involved in their care as much as they wanted to be = 100%

Improvement Opportunities

- Patients were told the reason for the long wait = 23%
- Patients got the appointment in 6 weeks or less = 79%

Strategies

- Communication- continue to remind staff to proactively inform patients about delays and provide updates on expected wait times during appointments.
- Scheduling- continue to prioritize urgent cases and optimize appointment allocation to ensure patients are seen sooner.

Summary

Patient Satisfaction surveys, monitoring and evaluation are important for identifying improvement opportunities to ensure we are meeting our patient needs and expectations are met. Regular assessments help enhance patient care and improve overall service quality.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other (please specify):

Date Prepared: February 5, 2025 Meeting Date Prepared for: Februay 12, 2025

Subject: Violent Incidents Review

Prepared by: Rachel Romany- Vice President Clinical Services, Quality and Chief Nursing Executive

☐ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☒ FOR INFORMATION ONLY

PURPOSE

- Provide an overview of the violent incidents for Q3
- Outline Code Black (Bomb Threat/ Suspicious Object) emergency protocol

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Violence within healthcare settings is a concern, impacting the safety and well-being of both our staff and patients.
- Understanding root causes of these incidents is crucial to implementing effective preventative measures.
- Code Black is the hospital emergency protocol for managing bomb threats or suspicious packages, ensuring the safety of staff, patients, and visitors.
- When Code Black is announced, it signifies that the hospital is facing an immediate threat of violence or a violent incident.
- The intended response to a Code Black involves immediate assessment, evacuation procedures (if necessary), and coordination with local authorities to address and neutralize the threat.
- Staff are trained in Code Black procedures, including recognition of suspicious items and actions to take in the event of a bomb threat.
- Mock Code White exercises are held at least once every three months.
- Staff are asked to keep three major priorities in mind:
  - Protect your own safety and that of others
  - Contain the threat so long as it does not compromise #1 above
  - Call for help (shout, call someone, call 911, etc.)

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.

No violent incidents were reported in Q3.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: January 15, 2025 Meeting Date Prepared for: February 12, 2025

Subject: Complaints and Compliments Q3

Prepared by: R. Romany, VP Clinical Services, Quality & CNE

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- Review the complaints and compliments for Q3 and discuss contributing factors and mitigation strategies for improvement

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☐ *No* ☒ *Yes, please specify:*

- Board Quality & Patient Safety Committee

SITUATION & BACKGROUND

A brief description of the background to the issue.

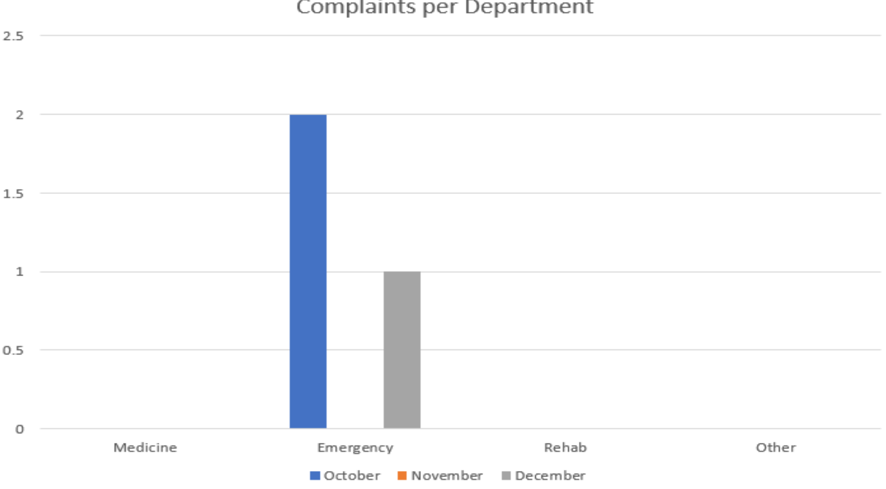
- Reviewing complaints and compliments is a crucial component of our commitment to transparency, continuous improvement, and patient centered care.
- A summary of the complaints and compliments received will be reviewed at Internal Quality and brought to Board Quality quarterly to keep the committee apprised of any situations that may arise.
- This summary highlights key trends, areas of concern, and notable achievements related to the quality of care and services provided by the hospital.

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

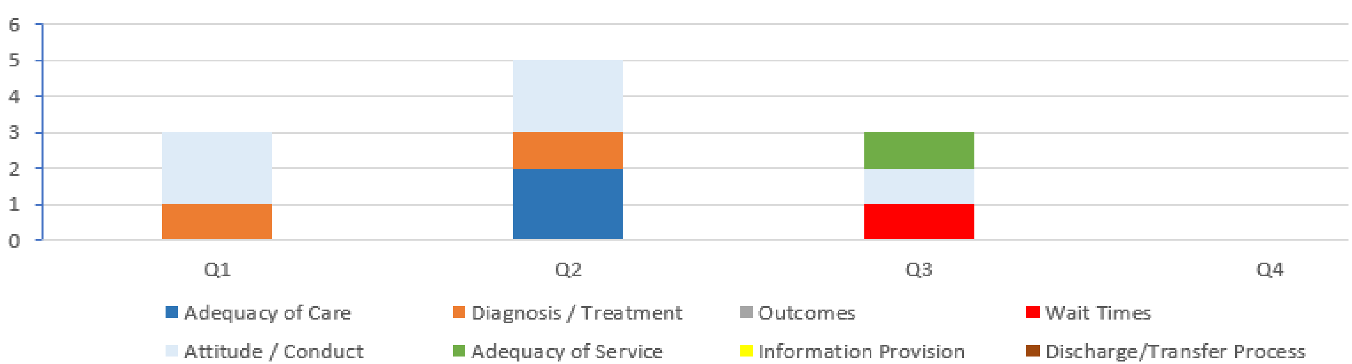
Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.

Complaints:

- In Q3, HGMH saw 5,049 patients in the emergency department.
- There was a total of 3 formal complaints received, all within the Emergency Department and related to physicians.

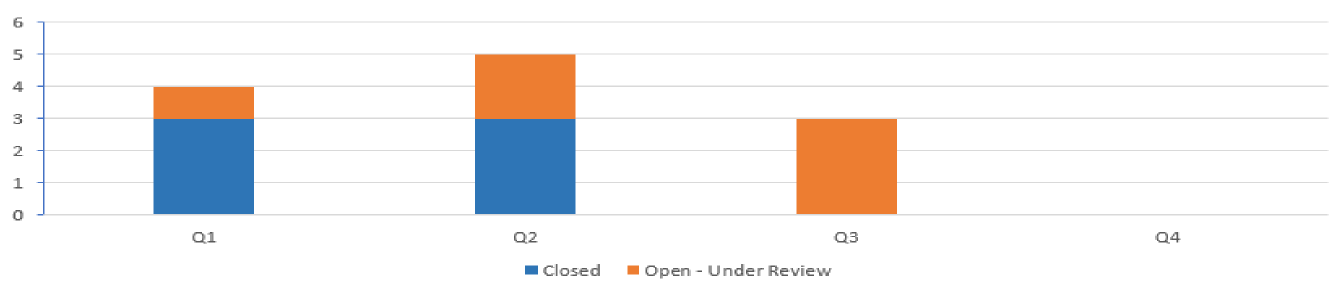


- Of the complaints received, two were related to the adequacy of care, one related to the diagnosis/treatment, and the last two were related to the attitude/conduct of staff. No complaints were received around the wait time.



- There are 6 unresolved complaints, all related to physicians. There is one outstanding complaint from last fiscal year related to nursing.

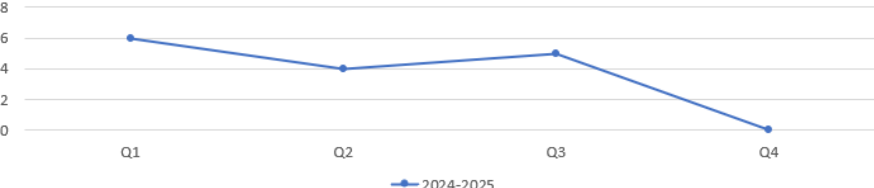
Complaint Status



Compliments:

During Q3, there were a total of 5 formal compliments received, with 3 of them for Medicine, and two of them for the Emergency Department all related to the care they received from nursing staff and physicians. Food Services and housekeeping staff were also acknowledged for their service. Most notably was a compliment from a patient commending staff for being prepared to help a deaf patient and treating this person with respect.

# of Compliments by Department per Quarter



SUMMARY

- Overall patients seem fairly appreciative of the service at HGMH.
- While we've received praise for our attentive care, there are areas for improvement highlighted in patient complaints, particularly regarding staff attitude/conduct.
- Ongoing strategies to address attitude and conduct are being looked into, including sharing out Patient Rights and Responsibilities on the walls and tv screens in waiting rooms.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: Jan 13, 2025 Meeting Date Prepared for: February 12, 2025

Subject: Patient and Family Advisory Committee (PFAC) Update

Prepared by: Rachel Romany- Vice President Clinical Services, Quality, Chief Nursing Executive

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To provide an update of the Patient and Family Advisory Committee (PFAC).

SITUATION & BACKGROUND.

- Benefits of PFAC presence in hospital committees:
  - help identify areas of improvement in care delivery processes
  - ensure that patient and family voices are heard and considered in decision-making processes
  - foster a culture of collaboration and partnership to promote patient-centered and inclusive healthcare practices

IMPLEMENTATION & COMMUNICATION

- Committee members are currently attending three hospital committees: Ethics, Product Evaluation, Quality and Safety Advisory.
- The members completed the Essential Caregiver Partner (ECP) program training to gain understanding of how patients can be effectively supported as part of the healthcare team.
- In October, members teamed up with HGMH staff and the SDG Library to launch the Library Partnership Program. Currently, this program isn't available for emergency department patients, as it may take up to 24 hours to process new accounts. We extend our heartfelt thanks to our PFAC committee for initiating and making this program a reality.
- During Canadian Patient Safety Week Oct 28- Nov 1, members were actively involved in planning and participating in events to showcase their role and presence in the hospital.
- Palliative and End of Life care presentation was provided to the PFAC and IDEA committee members.
- Members were asked to provide feedback on the resource booklet that will be provided to patients and their families. Improving family education on what to expect helps them focus on being present with their loved one.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors
☒ Board Committee – Quality & Patient Safety
☐ Senior Leadership Team
☐ Other (please specify):

Date Prepared: February 5, 2025   Meeting Date Prepared for: February 12, 2025

Subject: RNAO- Best Practice Spotlight Organization (BPSO) Update

Prepared by: Rachel Romany- Vice President Clinical Services, Quality, Chief Nursing Executive

☐ DECISION SOUGHT*   ☐ FOR DISCUSSION/INPUT   ☒ FOR INFORMATION ONLY

PURPOSE

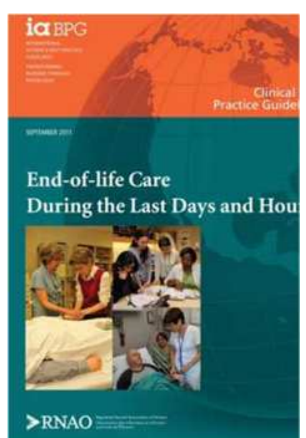
- Provide an update on the Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines (BPGs) for the 2024-2025

SITUATION & BACKGROUND

A brief description of the background to the issue.

- HGMH's focus for 2024-25 is on the following RNAO's Evidence- based Best Practice Guidelines (BPGs):
  - End-of-Life Care during the last days and hours
  - Oral Health: Supporting Adults who require assistance
- The team has completed gap analyses for the two BPGs.
  - The review includes an outline of best practice recommendations and comparing our existing practices and processes.
  - The review highlights crucial recommendations for patient and staff safety, identifies easy-to-implement quick wins that can enhance staff confidence, and notes partially implemented recommendations that are strong candidates for improvements.
- An interim RNAO BPSO lead, Carissa Auger, RPN, has been appointed to oversee the implementation of the two BPGs, data collection and reporting processes.

RNAO BPSO - End-of-Life Care Update

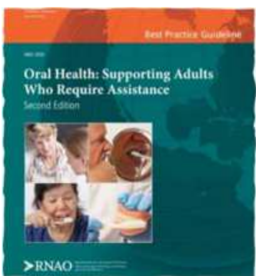


- Free LEAP Training: Available to staff to enhance knowledge of palliative care
- E-Learning Module: Created and shared via Intranet for easy access by all staff.
- Palliative Care Resource Nurse Role: Established to facilitate consultations and formalize family meetings
- Patient & Family Pamphlet: Updated "What to Expect When Your Loved One is Dying," distributed to patients receiving palliative care.
- Palliative Care Resource Booklet: Covers critical topics like spiritual care, grief support, and advance care planning.
- Upcoming Session: Feb 13 - "*Hospice: A Pitstop on the Way to Heaven*" with Dr. Diane Poilly.
- Palliative Care Resources: Available on the HGMH website for broader accessibility.

Key Elements for success

- Staff engagement and alignment with these best practice guidelines are essential in providing the highest standard of care, especially during this critical phase.
- Active staff participation ensures that our patients and their families receive the compassionate, quality care they deserve at this pivotal time in their journey.

RNAO BPSO - Oral Care Update



- E-Learning Module: Created and shared via Intranet to keep staff updated on oral care protocols.
- Weekly Updates & Reminders: Regular communication on oral care best practices via e-learning and charting updates in Meditech.
- Oral Care Champions: Staff appointed to promote and ensure adherence to oral care protocols.
- Oral Care Cards: Placed in patient rooms for easy access to care information and support.
- Caregiver Pamphlet: Created to highlight the importance of oral care for patients and families.
- New Oral Care Products: Exploring options such as denture brushes, better toothbrushes, and toothpaste.
- Session: Jan 31 - *Oral Care and Best Practice Guidelines* session with Dr. Jon Farmer.

This BPG provides recommendations to support the delivery of oral care— including appropriate supervision, prompting and assistance, while still advocating for the person's independence and autonomy.

Summary

- As a designated Best Practice Spotlight Organization (BPSO), HGMH is committed to continuously enhancing the quality of patient care through the implementation of evidence-based practices. This focus not only promotes safety and confidence among staff but also ensures that our patients and communities receive outstanding care.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality & Risk Management Committee ☐ Senior Leadership Team

☐ Other (please specify):

Date Prepared: February 5, 2025 Meeting Date Prepared for: February 12, 2025

Subject: Accreditation Update

Prepared by: Robert Alldred-Hughes, President & CEO

☐ DECISION SOUGHT* ☐ FOR DISCUSSION/INPUT ☒ FOR INFORMATION ONLY

PURPOSE

- To provide an overview of current activities and progress to ready HGMH for the 2026 Accreditation.

IMPLICATIONS TO OTHER STANDING COMMITTEES

Are there any material or significant implications for other Standing Committees? ☒ *No* ☐ *Yes, please specify:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

- Almost all Ontario Hospitals undergo an extensive accreditation process on a voluntary basis through Accreditation Canada who is a not-for-profit, independent organization accredited by the International Society for Quality in Health Care.
- They provide rigorous, evidence based, third-party evaluations, spanning a full spectrum of health and social services aligned with international leading practices and world class standards.
- HGMH completed the last accreditation in June of 2022, and was accredited with commendation. Following this survey, we took the approach in the spirit of continuous quality improvement that we would begin preparing for our next accreditation in the fall of 2022.
- The team leads and accreditation steering committee have been hard at work collecting evidence and ensuring the required organizational practices and standards are in place throughout the organization, and doing so in a fun and interesting way with our them of 'wizarding world'.
- At this point, the team is on track with the established workplan. An overview of current challenges and successes is as follows:
  - A total of 62 ROPs and 2 high priority criteria were removed and replaced with 150 new ROP tests for compliance as Accreditation Canada made amendments to the Required Organizational Practices (ROP) and Standards. This had a significant initial impact on the overall compliance on our teams tracking system, as the new criteria needed to be assessed for our current status. When the new ROPs were initially added, overall compliance dropped from over 80% to 76%, and ROP compliance dropped to only 34%. Since that time, in mid-December 2024, Prefects have reviewed almost all of the changes and updated the tracker accordingly, bringing overall compliance back to it's previous levels.

  - Since our last survey, Accreditation Canada had pulled all of the common criteria across multiple departments and assembled them into a single standard that applied facility-wide, called "Service Excellence" with 85 criteria. They have now replicated the Service Excellence standard across

departments individually. We now have five Service Excellence standards in our manual, for Inpatient Services, Emergency Services, Ambulatory Care, Diagnostic Imaging, and Rehabilitation Services. This means the same 85 criteria are now assessed five times by surveyors. Work is already underway to systematically review and update the status of each of these.

- o With the two points above having significant impact on the overall compliance rates in the tracking system, as of February 5, 2025, we stand at 74% overall compliance and 70% compliance with ROPs specifically.

- o The Global Workforce Survey has been completed, receiving 93 responses (51.7%); the minimum response rate was 50% in order to qualify for accreditation with commendation or exemplary standing. The results are still pending compilation due to an issue with the Accreditation Instrument Portal, and work is ongoing with their team to resolve it.

- o The Governing Body Assessment has been sent out and so far has 10/12 responses (target response rate of 80% has been achieved). The current closure date is set for February 28, 2025.

- o Staff participation in “Accreditation Wizardry Assignments” continues to be excellent, with a total of 541 assignments submitted from 75 participants since the program began in November 2023. Staff clearly enjoy the friendly competition between Wizarding Houses to earn the most points to win the prize each three-month period.

- o Current efforts related to Accreditation are focussed on ensuring that evidence is documented for each item on the tracker and that the status of each criteria’s compliance is noted accurately.

- Next steps with Accreditation are expected to be:
    - o Jan-March 2025: Survey planning form completion
    - o July: Submission of attestation
    - o November/December: Submission of evidence to portal
    - o November/December: Pre-survey logistics & planning
    - o Onsite survey some time between January-March (with 2-3 weeks notice of actual survey dates)

CONSULTED WITH:

Indicate those bodies and individuals who have been consulted with in the development of this decision support document

- Jennifer Mattice, Manger of Emergency Preparedness, Projects, & Security

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared: February 5, 2025 Meeting Date Prepared for: February 12, 2025

Subject: Accreditation Standard Feature

Prepared by: Rachel Romany, Vice President Clinical Services, Quality, Chief Nursing Executive

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- As part of the hospital's efforts to embrace the new continuous model for Accreditation and embed it into our daily work, committees will feature 1-2 criteria from an Accreditation standard that applies to their committee's work at each meeting
- These features will provide an opportunity for the team to discuss the standard and how HGMH achieves compliance, while ensuring the committee is well-equipped to make informed decisions and recommendations related to quality

STANDARD / CRITERIA FEATURED

Include the standard name, number(s), statement(s), guideline text, and other information if applicable

- 3.1.7 The governing body ensures that the organization uses client feedback to improve the quality of services.
  Priority Normal Quality Dimension Appropriateness

- Guideline 3.1.7 :
  The governing body ensures that the organization collects feedback on client experience and satisfaction to use for evaluation and improvement of its services. Client experience includes all interactions a client and family have with the organization throughout the client journey. Client satisfaction data measures whether client expectations were met. These data vary from client to client based on each client's expectations of care…The governing body ensures that the organization uses its finding to inform its quality improvement planning.

DISCUSSION QUESTIONS

- What does this standard mean to you / why is it important for this team?
- What does the hospital already do to meet this standard?
- How does this committee contribute to meeting this standard?
- What elements of patient experience are included in a patient satisfaction survey?
- Are these elements addressed in quality improvement plan?

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality ☐ Senior Leadership Team
☐ Other *(please specify):*

Date Prepared:	Jan 13, 2025	Meeting Date Prepared for:	February 12, 2025
Subject:	Patient Safety Plan 2022-2028 Actions		
Prepared by:	Rachel Romany- Vice President Clinical Services, Quality, Chief Nursing Executive		

☐ DECISION SOUGHT* ☒ FOR DISCUSSION/INPUT ☐ FOR INFORMATION ONLY

PURPOSE

- To provide an update of the Patient Safety Plan actions.

SITUATION & BACKGROUND

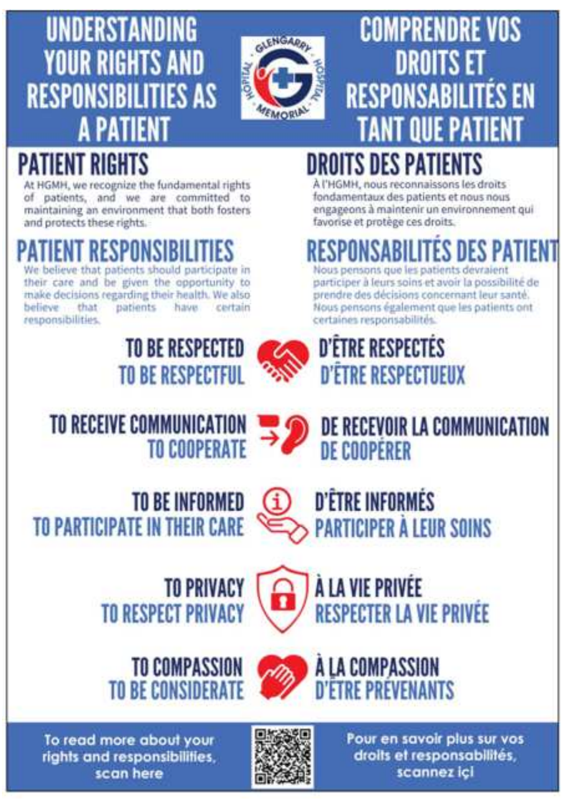
A brief description of the background to the issue.

- The Patient Safety Plan is to communicate and support our focus and commitment to the provision of safe, quality patient care.

IMPLEMENTATION & COMMUNICATION

Consider how this will be rolled-out or shared as information

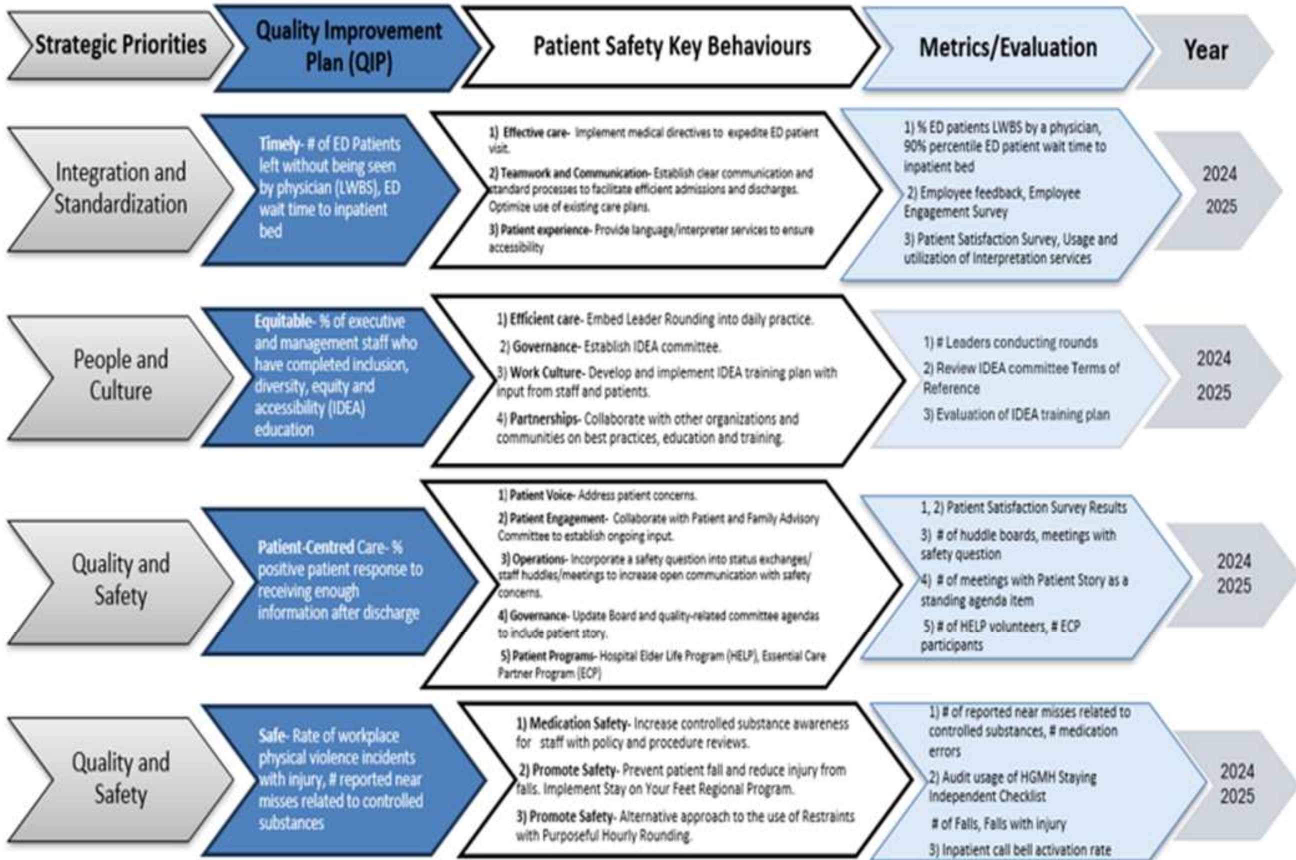
- The Patient Safety Plan includes the Patient rights and responsibilities as per Accreditation recommendations.
- Patient Rights and Responsibilities poster



- Patient Safety Key behaviors:
  - People and Culture: Leader rounds are being conducted.
  - Patient Centred Care: Safety question is included in huddles/ committees for open communication of safety concerns.
  - Equitable: Ongoing micro-learning modules from Culture Ally are being completed by leadership team and the Board of Directors.
  - Patient Voice and Engagement: PFAC members are participating in the Ethics, Product Evaluation, and Quality and Safety Advisory committees to offer input from a patient perspective.
  - Safety: continuous assessment of reported near misses involving controlled substances and medication errors that reached the patient.

Patient Safety Plan- Safety Behaviours for Improved Quality Care

This plan is in alignment with the Quality Improvement Plan and is updated annually to ensure continuous improvement of patient outcomes and quality of care.



SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Patient Safety Plan

PATIENT SAFETY PLAN

2022-2028

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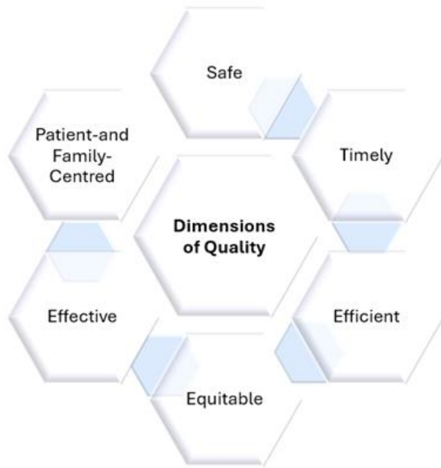
Patient Safety Plan

The **Mission** at Hôpital Glengarry Memorial Hospital (HGMH) is *delivering outstanding care for our communities*, which fuels the **Vision** of *providing your care, your way, with seamless integration, innovation, and equitable access for our communities*.

We envision being a recognized leader in the delivery, promotion, and integration of health care services. It is our aim that everyone accessing care at our hospital receives an exceptional patient experience delivered by staff and physicians who consistently demonstrate our **Values**, our "PACT" to have **P**assion, **A**ccountability, **C**ompassion & **T**eamwork at the heart of all we do, everyday.

The intention of the Patient Safety Plan is to communicate and support our focus and commitment to providing safe, quality care while achieving optimal patient outcomes. It is designed to improve patient safety, reduce risk, and respect the dignity of our patients by assuring a safe environment.

Our Patient Safety Plan aligns with the **Ontario Health Quality model** that views quality through six dimensions: *safe, timely, effective, patient-centred, efficient, and equitable.*



Patient Safety Plan Objectives

Patient Safety Plan Guiding Principles

Guiding Principles

- We **believe** that patient safety is at the core of a quality healthcare system.
- We **value** the perspectives, experiences, and contributions of all staff, physicians, volunteers, patients, and caregivers, in their role in patient safety.
- Patient Safety is a **continuous pursuit** and is embedded in how we do all our work.
- **Accountability** for patient safety is everyone's responsibility: from the Board of Directors to frontline staff to volunteers.
- We **promote** a safety culture in which staff/physicians feel safe reporting adverse events, errors, and near misses. These reports inform our improvements to care.
- We will **foster** a culture within HGMH and within our partners that respects diversity and inclusivity as a shared responsibility, promoting access and equity for staff/physicians and patients.
- We will **strive** to remove barriers to services for patients and staff/physicians with respect to language and accessibility.

Patient Rights and Responsibilities

Patient Rights

When you are in our hospital, we recognize the fundamental rights of patients and we are committed to maintaining an environment that both fosters and protects these rights.

Respect

- Every patient has the right to be treated with courtesy and dignity in a way that recognizes individuality and is free of prejudice.
- Accommodation in a safe and clean environment that is free from abuse.

Communication

- To have your condition, care, and treatment explained to you or to your substitute decision maker in simplified terms to the best of the health care provider's ability; and to participate in one's care plan in either official language.
- To be introduced to and informed of the professional status of individuals providing care and service.

To be informed

- To receive ongoing information concerning your diagnosis, treatment, and any known prognosis and to consent to service knowing the consequence of refusal.
- To receive information regarding available healthcare services and options when planning for admission, discharge, or transfer from the hospital

Privacy

- To have your personal health information kept private in accordance with the Privacy Act.
- To request that your admission to the hospital not be disclosed to certain individuals.

Compassion

- To have a parent, guardian, family member, essential care partner, or friend stay with you 24 hours per day in special circumstances.
- Pastoral and palliative care services

Patient responsibilities

Hôpital Glengarry Memorial Hospital believes that patients should participate in their treatments and be given the opportunity to make decisions regarding their health. We also believe that patients have certain responsibilities.

Respect

- Every person working, volunteering, visiting, or receiving services from HGMH has the right to be treated with courtesy, dignity and respect.

Consideration

- Be considerate and respectful of health care providers and other patients and families.
- Be considerate of other patients and respect their privacy.

Cooperation

- To provide accurate information about your past illnesses, previous hospitalizations, and medications and to report any unexpected changes in your condition.
- To follow the treatment plan as discussed and mutually agreed by you and your physician.
- To keep appointments or to contact the hospital when this is not possible.

Safety for Everyone

- To observe the hospital isolation and smoking restriction policies
- Follow instructions during emergency measures and outbreak of infections.
- Verbal and physical abuse will not be tolerated.

Participation

- To make appropriate and timely arrangements for leaving the hospital upon discharge by your physician.

Patient Safety Plan- Safety Behaviours for Improved Quality Care

This plan is in alignment with the Quality Improvement Plan and is updated annually to ensure continuous improvement of patient outcomes and quality of care.

Strategic Priorities	Quality Improvement Plan (QIP)	Patient Safety Key Behaviours	Metrics/Evaluation	Year
Integration and Standardization	**Timely**- # of ED Patients left without being seen by physician (LWBS), ED wait time to inpatient bed	**1) Effective care**- Implement medical directives to expedite ED patient visit. **2) Teamwork and Communication**- Establish clear communication and standard processes to facilitate efficient admissions and discharges. Optimize use of existing care plans. **3) Patient experience**- Provide language/interpreter services to ensure accessibility	1) % ED patients LWBS by a physician, 90% percentile ED patient wait time to inpatient bed 2) Employee feedback, Employee Engagement Survey 3) Patient Satisfaction Survey, Usage and utilization of Interpretation services	2024 2025
People and Culture	**Equitable**- % of executive and management staff who have completed inclusion, diversity, equity and accessibility (IDEA) education	1) **Efficient care**- Embed Leader Rounding into daily practice. 2) **Governance**- Establish IDEA committee. 3) **Work Culture**- Develop and implement IDEA training plan with input from staff and patients. 4) **Partnerships**- Collaborate with other organizations and communities on best practices, education and training.	1) # Leaders conducting rounds 2) Review IDEA committee Terms of Reference 3) Evaluation of IDEA training plan	2024 2025
Quality and Safety	**Patient-Centred** Care- % positive patient response to receiving enough information after discharge	**1) Patient Voice**- Address patient concerns. **2) Patient Engagement**- Collaborate with Patient and Family Advisory Committee to establish ongoing input. **3) Operations**- Incorporate a safety question into status exchanges/ staff huddles/meetings to increase open communication with safety concerns. **4) Governance**- Update Board and quality-related committee agendas to include patient story. **5) Patient Programs**- Hospital Elder Life Program (HELP), Essential Care Partner Program (ECP)	1, 2) Patient Satisfaction Survey Results 3) # of huddle boards, meetings with safety question 4) # of meetings with Patient Story as a standing agenda item 5) # of HELP volunteers, # ECP participants	2024 2025
Quality and Safety	**Safe**- Rate of workplace physical violence incidents with injury, # reported near misses related to controlled substances	**1) Medication Safety**- Increase controlled substance awareness for staff with policy and procedure reviews. **2) Promote Safety**- Prevent patient fall and reduce injury from falls. Implement Stay on Your Feet Regional Program. **3) Promote Safety**- Alternative approach to the use of Restraints with Purposeful Hourly Rounding.	1) # of reported near misses related to controlled substances, # medication errors 2) Audit usage of HGMH Staying Independent Checklist # of Falls, Falls with injury 3) Inpatient call bell activation rate	2024 2025

HGMH Patient Safety Program

Internal: Ongoing Patient Safety Initiatives not limited to:

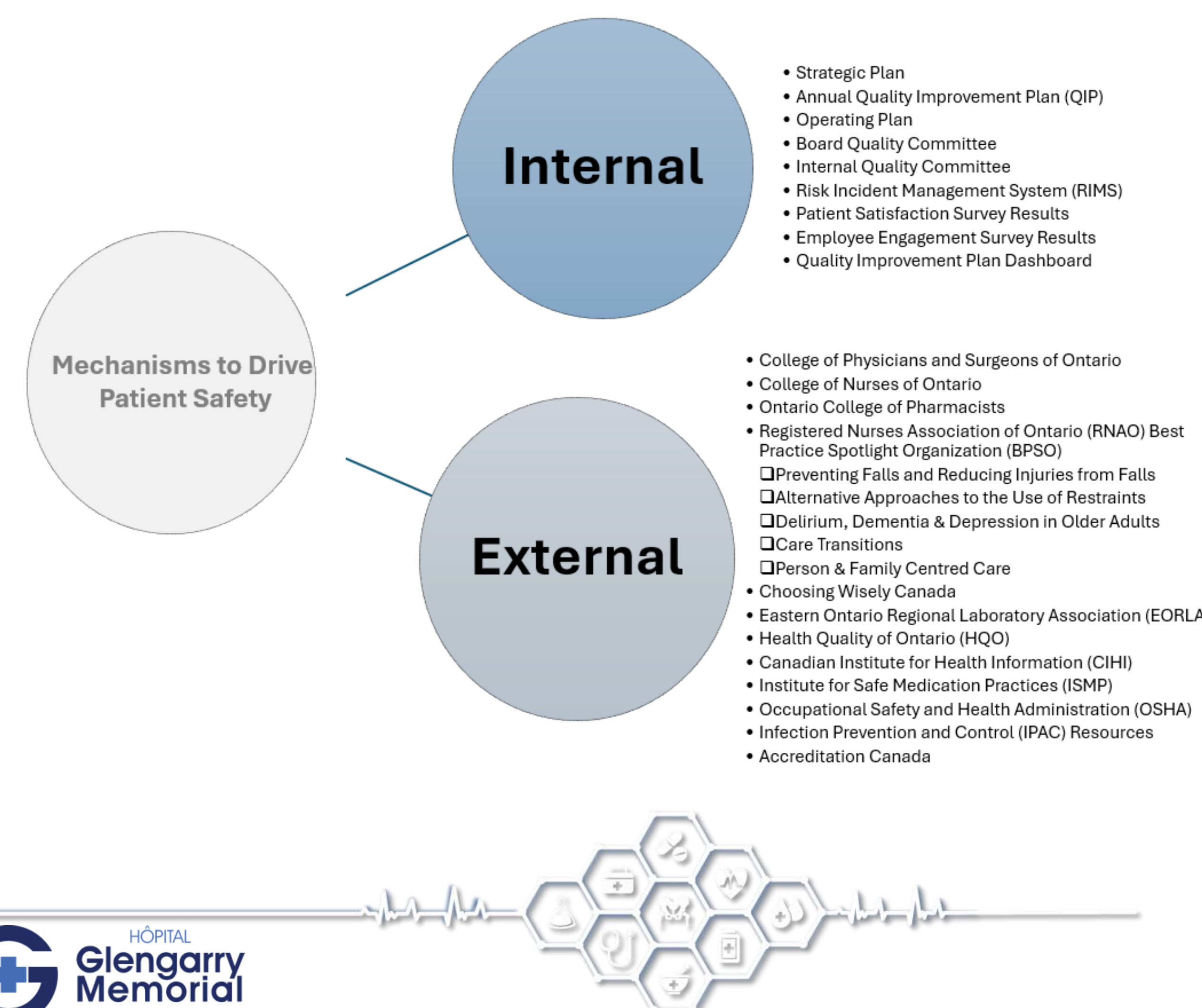
Safety	
• Huddles- Quality Boards • Discharge Rounds • Orientation • Monthly Safety Talks • Purposeful Hourly Rounding	• Bedside Medication Verification • Clinical Education Support • Clinical Informaticist Support • Reporting of Adverse Drug Reactions and Medical Device Incidents under Vanessa's Law
Quality Indicators	
• PPE Donning and Doffing Audits • Equipment Audits • Critical Care Indicators for Antibiotic Resistant Organisms and Healthcare Associated Infections	• Blood Product Transfusion Reactions • Use of Restraints
Safety Programs	
• Immunization Programs • Emergency Preparedness Committee • Infection Prevention and Control Program • Preventative Maintenance Program	• Occupational Health & Safety • Antimicrobial Stewardship Program • Accreditation Canada • Violence Prevention Program
Environmental Safety	
• Product Recalls • Drug Recalls • Product/Equipment malfunction • WHIMIS Training for all Staff/Physicians	• Air Quality • Workplace Violence Incidents • Cyber Security

External: Accreditation Canada Required Organizational Practices (ROPs)

Safety Cultures	• Measuring quality indicators at different levels throughout the organization • Patient and Family Advisory Committee's focus on quality of care and patient safety • RIMS to report and track incidents for our patients and staff/physicians and assess risk in the organization
Communications	• Medication Reconciliation • Transfer of Accountability • Staff and Patient Rounding • National Early Warning System (NEWS2) • Secure "My Chart" platform allowing patients access to their medical record
Medication Use	• Venous Thromboembolic Prophylaxis (VTE) • Audits of safety reports for medication incidents • Infusion pump training, evaluation of competence, and monitoring of reports
Infection Prevention & Control	• Ongoing monthly hand hygiene data collection • Orientation and education of staff/physicians, patients, and families on hand hygiene practices and Personal Protective Equipment (PPE) • Healthcare Associated Infections (HAI) investigation, monitoring, and reporting
Risk Assessment	• Falls and Medication errors reported and tracked in RIMS • Quality Reviews and Quality of Care reviews (under the Quality of Care Information Protection Act [QCIPA]) for high risk and critical incidents • Risk assessments for falls, pressure injuries and delirium
Work life/Workforce	• Workplace Violence Prevention: Critical Care Indicators Flagging Program for potential and actual violent patient behaviour • Non-Violent Crisis Intervention (NVCI) training • Gentle Persuasive Approach (GPA) education

Internal and External Mechanisms to Drive Patient Safety

HGMH strives for the best possible care and upholds patient safety through integrated internal and external system and processes. Our Patient Safety Plan is designed to support and align with our Strategic Plan priorities, our Quality Improvement Plan, our Operating Plan, and ongoing quality and patient safety initiatives. It is guided in compliance with and adherence to Accreditation Canada's Required Organizational Practices and recognizing the work of other accreditation bodies such as but not limited to: Institute for Quality Management in Healthcare (IQMH) focused on Laboratory Accreditation, and Ontario College of Pharmacists Accreditation Program.



Governance Structure that Supports Patient Safety

Board

Board of Directors-legislated to be responsible for patient safety and protection as well as the quality of care provided at HGMH.

Quality Committee of the Board- oversee the quality and safety activities at HGMH, the annual Quality Improvement Plan, and make recommendations to the board.

Senior Leadership Team

delegated by the Board to be stewards of organizational quality and patient safety; commits and supports a culture of excellent care and continuous quality improvement

Medical and Clinical Leadership

Quality and Safety Advisory Committee-manage internal quality of care and patient safety and reports to the Board Quality Committee

Medical Advisory Committee- responsible for assuring that quality medical care is delivered, that professional medical practice is advanced, and that Professional Staff function as partners in the care of patients.

Ethics Committee- ensures that ethical issues are considered through the HGMH Supporting Ethical Decision-Making Framework.

Clinical and Corporate Programs

Department Quality and Patient Safety Quality Boards

Patient and Family Advisory Committee- Incorporates the voice of the patient on our committees and improvement teams, through all stages of work, from planning through to evaluation

External Partnerships

Accreditation Canada
Health Quality Ontario
Great River Ontario Health Team
Champlain Association of Meditech Partners (CHAMP)
Ontario Caregivers Association
Ontario Hospital Association

HGMH Patient Safety Plan provides a framework for action in our quality care journey. We are committed to ongoing dialogue and co-creation of initiatives with patients and families. We are confident that the priorities and commitments identified provide clear direction and enhances our partnership with patients and their families to optimize quality and patient safety at HGMH.

HGMH Performance and Measurement System