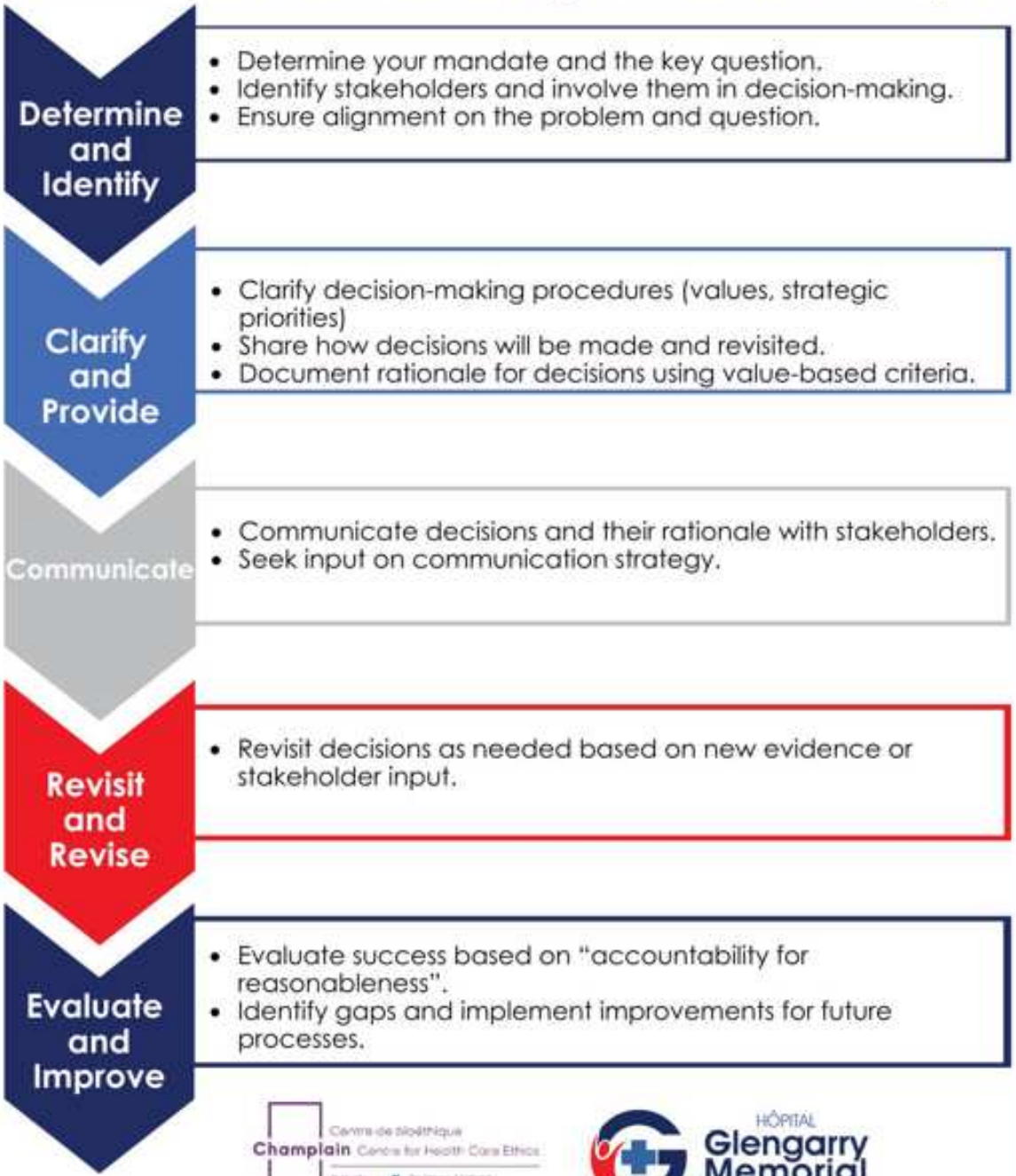
BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING AGENDA

Date: Wednesday, May 14, 2025
Time: 19H00 – 20H30
Location: Boardroom / Microsoft Teams

Time	Agenda Item	Board Item	Attachment
19:00	**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		
19:03	**2.Report from Last Meeting**		
(1 min)	2.1 Approval of previous meeting report – February 12, 2025		P. 3-6
(1 min)	2.2 Business arising from the report		
(1 min)	2.3 Committee Work Plan Check In		P. 7
19:06	**3. Education Session**		
(10 min)	3.1 Quality Initiatives – Akwesasne Endoscopy (R. Romany)		
19:16	**4. Matters for Discussion/Decision**		
(5 min)	4.1 Review Q4 Quality Improvement Plan Results (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Q4 Quality Improvement Plan Results for 2024/2025 as presented.**	D	P. 8-11
(5 min)	4.2 Review Q4 Clinical Quality & Safety Scorecard (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Q4 Quality & Safety Scorecard results as presented.**	D	P. 12-15
(5 min)	4.3 Review Q4 Patient Satisfaction Survey Results (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Q4 Patient Satisfaction Survey results as presented.**	D	P. 16-19
(5 min)	4.4 Review Q4 Violent Incidents Report (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Q4 Violent Incident report as presented.**	C	P. 20
(5 min)	4.5 Review Q4 Complaints & Compliments Report (R. Romany) **THAT the Quality & Patient Safety Committee review and receive the Q4 Complaints and Compliments report as presented.**	C	P. 21-22
(5 min)	4.6 Review Recommendations from Quality Reviews (R. Romany)	C	P. 23
(5 min)	4.7 Kids Come First Regional Pediatric Surgery Update (R. Alldred-Hughes) **That the Quality & Patient Safety Committee review and receive this update for information and continue to endorse HGMH's participation in the Kids Come First Health Team's efforts to regionalize pediatric surgical care.**	D	P. 24-25
(5 min)	4.8 Surgical Report (R. Alldred-Hughes) **That the Quality & Patient Safety Committee review and receive the Surgical Expansion Options Analysis Overview and support a phased advancement of surgical expansion opportunities, recognizing that implementation will be sequenced following the EPIC EMR go-live and stabilization period, and integrated with the future deployment of EPIC's surgical module.**	D	P. 26-27
(5 min)	4.9 Quality & Patient Safety Framework Policy (R. Romany) **THAT the Quality & Patient Safety Committee recommend to the Board of Directors the approval and implementation of the Quality & Patient Safety Framework Policy as presented.**	C	P. 28-35
(5 min)	4.10 HIROC Report (R. Alldred-Hughes) **THAT the Quality & Patient Safety Committee review and receive the Hospital Insurance Reciprocal of Canada historical claims submission.**	C	P. 36-40
19:56	**5. Matters for Information**		
(5 min)	5.1 Report from VP Clinical Services, Quality & CNE on Quality Initiatives (R. Romany)	C	P. 41-42
(5 min)	5.2 Accreditation Updates (R. Alldred-Hughes)		P. 43-44
(5 min)	5.3 Accreditation Standard Review (R. Romany)		P. 45
(5 min)	5.4 Ethics Committee Update (R. Romany)	C	P. 46
(5 min)	5.5 Emergency Preparedness Updates (R. Alldred-Hughes)	C	P. 47-48
(5 min)	5.6 Policy – Guidelines for Managing Physician Professional Behavior (Dr. L. MacKinnon)	C	P. 49-59
20:26	**6. Date of Next Meeting**		
	September 2025		
20:27	**7. Adjournment**		

Board Item: Matters for Discussion/Decision (D) or Consent Agenda (C)
*Refer to the Accountability for Reasonableness (A4R) framework for organizational ethical issues.

Accountability for Reasonableness (A4R) Ethical Decision Making Framework Steps



REPORT OF THE BOARD QUALITY AND PATIENT SAFETY COMMITTEE MEETING

February 12, 2025 at 6:00PM via MS Teams

Present:	C. Larocque	Dr. S. Robertson	G. Peters
	H. Salib	Dr. R. Cardinal	R. Romany
	R. Alldred-Hughes	Dr. L. MacKinnon (6:51)	C. Mageau-Pinard
Regrets:	W. Rozon		

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 November 13, 2024, was approved as presented.
Moved By: H. Salib
Seconded By: G. Peters
THAT the report of November 13, 2024, be approved as presented.

CARRIED

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

Committee Work Plan Check In:
Things are on track with the committee workplan.

Education – Patient Story (R. Romany)

R. Romany presented a patient story in which a previously independent patient was diagnosed with a brain bleed with ruptured aneurysm and a coiling procedure was performed. This patient was referred to the hospital rehabilitation program from the stroke center. During their hospital stay, the patient had difficulty with orientation, multiple falls after being admitted, loss of bladder control, impulsive behaviour, and difficulty staying focused and following instructions.

An action plan was put in place including physical therapy, cognitive support, fall prevention strategies and an Essential Care Partner was identified for the patient to provide support and advocacy. Learnings from this case were that early identification of an Essential Care Partner is crucial for transition to the next recovery phase as they help provide physical, psychological, and emotional support to the patient.

Matters for Discussion/Decision

Professional Staff Appointment and Re-appointment Review

The Professional Staff Appointment and Re-appointment process was reviewed.

Moved By: Dr. R. Cardinal
Seconded By: H. Salib
THAT the Quality & Patient Safety Committee review and receive the Professional Staff Appointment and Re-appointment process as presented.

CARRIED

Quality of Care Information Privacy Act Policy

The Quality-of-Care Information Privacy Act Policy was reviewed.

Moved By: G. Peters
Seconded By: Dr. R. Cardinal
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.

This policy was created in 2006, and the last review of the policy was done in 2017. As such, this policy was due for review and was revised to reflect the legislative framework. Recommendations from Quality reviews will be brought back to the committee. Two quality reviews were done and will be brought back to the committee for discussion.

CARRIED

Review Q3 Quality Improvement Plan Results 2024/2025

The Quality Improvement Plan results for Q3 of 2024/2025 were reviewed.

Moved By: H. Salib
Seconded By: G. Peters
THAT the Quality & Patient Safety Committee review and receive the Quality improvement Plan Results for Q3 2024/2025 as presented.

The results are trending positively. There was a mistake noted under education in which should read 90% as this is cumulative. Discussion ensued on number of reported near misses related to controlled substances within the organization in which the target is quite low and not achievable, however, these are not reaching the patient as the pharmacy team continues to work on providing constructive feedback and additional training where necessary.

CARRIED

Quality Improvement Plan 2025/2026

The proposed Quality Improvement Plan for 2025/2026 was reviewed.

Moved By: H. Salib
Seconded By: Dr. R. Cardinal
THAT the Quality & Patient Safety Committee recommend to the Board of Directors the approval of the Quality Improvement Plan for 2025/2026 and the narrative as presented.

R. Romany explained the process for coming up with the Quality Improvement Plan in which Ontario Health provides recommended metrics. The focus remains on four province-wide priority issues which include Access and Flow, Equity, Experience, and Safety which means that the indicators will remain the same as last year with updated target performances.

CARRIED

Review Q3 Quality & Safety Scorecard Results
The Q3 Quality & Safety Scorecard results were reviewed.

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

Things are trending positively with no overall concern.

CARRIED

Review Q3 Patient Satisfaction Survey Results
The results of the Patient Satisfaction Surveys were reviewed for Q3.

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

The format was changed for clarity. Discussion ensued around communicating wait times in the Emergency Department. This can be a challenge to communicate as the time is constantly changing depending on the severity of cases. Overall, responses are positive.

CARRIED

Review Q3 Violent incident Report
No violent incidents were reported in Q3.

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

Review Q3 Complaints and Compliments Report
The complaints and compliments report for Q3 was reviewed.

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

In Q3, there were 5,049 patients seen in the Emergency Department. A total of three formal complaints were received, all within the Emergency Department and related to wait times, attitude and conduct, and adequacy of service. When behavioral complaints are received, the process for staff and physicians are different as physicians are not employees of the hospital. The Guidelines for Managing Physician Professional Behavior will be shared at the next meeting.

There were five compliments received with three of them for the Medicine unit, and two for the Emergency Department, all related to the care received. The most notable compliment received was to commended staff for being prepared to help a deaf patient and treating this person with respect.

CARRIED

Matters for Information

Patient & Family Advisory Committee Update

A family space is being worked on within the hospital in which the Patient & Family Advisory Committee will be engaged.

Best Practice Spotlight Organization Update

Things are wrapping up with this years two best practice guidelines. Training sessions are being offered to staff on Palliative Care as well as Oral Care. Resource documents were created to share with patients and families and weekly updates and reminders are shared with staff on best practices.

Accreditation Update

The team is on track with an established workplan for Accreditation. A total of 62 ROPs and 2 high priority criteria were removed and replaced with 150 new ROP tests for compliance. This created significant impact on the overall compliance of our team's tracking system. Teams reviewed almost all of the changes and updated the tracker accordingly to its previous levels with 74% overall compliance and 70% compliance with ROPs specifically. The Governing Body Assessment was sent out and so far 10 our 12 responses were received with the closure date set for February 28, 2025.

Accreditation Standard Review

R. Romany presented the Accreditation standard 3.1.7 The governing body ensures that the organization uses client feedback to improve the quality of services.

It was discussed that the IDEA committee has been tasked with filtering the patient satisfaction survey results by demographics from a diverse perspective and identifying their experience in comparison with the group of non-diverse population and identify action items.

Review Status of Patient Safety Plan Actions

The patient safety plan actions were reviewed and remain ongoing with no concerns.

Date of Next Meeting: May 14, 2025

K-L. Massia, Recorder

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		✓		✓	
Quality Initiatives	CNE			✓		X
QUALITY OVERSIGNT AND IMPROVEMENT						
Review QIP Dashboard	CNE	Quarterly	✓	✓	✓	X
Recommend QIP Dashboard 2025-2026	CNE	Yearly			✓	
Clinical Quality & Safety Scorecard	CNE	Quarterly	✓	✓	✓	X
Review Patient Satisfaction Survey Results	CNE	Quarterly	✓	✓	✓	X
Violent Incidents Report	CNE	Quarterly	✓	✓	✓	X
Review Life or Limb Results	CNE	When available				
Review Complaints & Compliments Report	CNE	Quarterly	✓	✓	✓	X
PFAC Update	CNE	Quarterly	✓	✓	✓	X
Review Critical Events and Never Events Report	CNE	Yearly		✓		
BPSO Update	CNE	Quarterly	✓	✓	✓	X
Review Patient Safety Plan	CNE	Yearly			✓	
Review Status of Patient Safety Plan Actions	CNE	Quarterly	✓	✓	✓	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
Accreditation Standard Review	CNE	Quarterly	✓	✓	✓	X
ESTIMATED PREPARATION TIME FOR MEETING						

Revisions since prior report:

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

Updated July 10, 2024

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: April 15, 2025 Meeting Date Prepared for: _____

Subject: Quality Improvement Plan (QIP) Results- Q4

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

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

PURPOSE

- Reviewing the results of the Quality Improvement Plan for Q4
- 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 Q4 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%	6.1%	7.8%	5.0%	6.3%	8.0%

- Q4 ended with 6.3%, achieving the target of staying below 7.7%. This is a significant improvement from the previous year's 8.8%, especially considering the current ED initiative only launched in July 2024.
- Strategy(ongoing): 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. A huge thank you to the entire team for driving these results forward. This demonstrates the impact of thoughtful planning and collaboration.

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	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	3.3	4.8	2.8	3.6	3.1

- Q4 ended with 3.6 hours, which is positively below the target of 6 hours.
- Strategy (ongoing): continuous improvement processes such as clear communication protocols between ED and inpatient team to ensure seamless transitions and faster response times help us reach this achievement.

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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

- Q4 ended with 100% completion demonstrating strong organizational alignment with our commitment to IDEA.
- Strategy(ongoing): 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 is more than a checkbox as it represents a deepened commitment to embedding equity and inclusion into our everyday leadership practices.
- By promoting ongoing learning and collaboration at the highest levels of the organization, we're reinforcing a culture that values and supports equitable care for all. Thank you to our leaders and board members for championing this important work.

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%	93.3%	93.6%	91.7%	92.9%	88.0%

- Q4 ended with 92.9%, which achieves above the target of 86%.
- Strategy(ongoing): Consistently ensure that discharge instructions are clear and thorough, emphasizing patient understanding. Staff continue to focus on effective communication, especially around time-sensitive conditions and follow-up care instructions.

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%	0.0%	0.0%	0.0%	0.0%

- Q4 ended at 0% incident rate, successfully meeting the target of zero staff lost time injuries.
- Strategy(ongoing): Continued focus on proactive approaches to avoid or reduce violent incidents, fostering 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	17	27	19	21	26	26	21	24	16	6	7	10	242

- Q4 ended at 10 incidents, staying below the target of 12, which is a positive outcome.
- Strategy(ongoing):
  - Continuously evaluate medication dispensing and documentation processes.
  - Monitor narcotic counts closely and investigate any discrepancies or potential losses in a timely manner.
  - Gather regular feedback from staff to identify gaps and areas for improvement.
  - Provide constructive feedback and targeted training based on identified needs.
  - Integrate diversion prevention education into the orientation program for all new employees to promote a culture of safety and accountability.

Summary

The Quality Improvement Plan 2024–25 highlights our success in achieving all but one Q4 target, demonstrating strong overall performance. It reinforces that ongoing teamwork and collaboration are vital as we continue to build on these achievements and focus on areas where improvement is still needed.
We also acknowledge the significant dedication, effort, and coordination that go into these initiatives, recognizing the commitment of our teams to delivering safe, high-quality care every day.

HÔPITAL Glengarry Memorial HOSPITAL

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%	6.1%	7.8%	5.0%	6.3%	8.0%
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	3.3	4.8	2.8	3.6	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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
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%	93.3%	93.6%	91.7%	92.9%	88.0%
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%	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	17	27	19	21	26	26	21	24	16	6	7	10	242

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: April 15, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Clinical 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 Q4 results of the Clinical 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
    - Turnover Rate (% of nursing staff who left the organization voluntarily or involuntarily
    - Nursing - % Paid Overtime Hours
    - Percent of respondents answering yes to the question "did you participate in your plan of care?"
    - Percent of respondents answering yes to the question "were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?"
  - Safety and Effective Care
    - Fall Rate, Falls with injury
    - Physical violence incidents, restraint use
    - Appropriate blood transfusion rate
    - Functional decline assesment
    - Medication errors, percentage of patients receiving appropriate VTE prophylaxis
    - Compliance rate with use of order sets- COPD
    - 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.

Highlights of Key Achievements:

- Timely Access to Care:

- *Emergency Department wait time to inpatient bed – Target: 6.0 hours, Achieved: 3.6 hours*
  This demonstrates a major win for patient flow and bed management, reducing stress on both patients and clinical teams.

- Staff Retention & Stability:
  - *Nursing turnover (voluntary/involuntary) – Target: 5.0%, Achieved: 2.5%*
    A testament to our ongoing supportive work environment and commitment to staff wellbeing.
- Patient-Centered Care:
  - *Patients reporting involvement in their plan of care – Target: 80%, Achieved: 95.7%*
    This reflects our dedication to shared decision-making and personalized care.
- Clinical Appropriateness & Safety:
  - *Appropriate use of blood transfusions – Target: 75%, Achieved: 100%*
    Evidence of strong clinical governance and adherence to best practices.
- Medication Safety:
  - *Medication errors reaching the patient – Target: 52, Achieved: 44*
    A strong performance in medication safety, with continued opportunity for improvement.
- Infection Control Excellence:
  - *Hand hygiene compliance (Moment 4) – Target: >92%, Achieved: 95.7%*
  - *Hospital-acquired infection (HAI) – VRE – Target: 0, Achieved: 0*
    These results highlight ongoing promotion of the culture of accountability and vigilance in infection prevention.
- Health Equity & Accessibility:
  - Translation services usage – Target: 50 minutes, Achieved: 293 minutes
    A significant increase reflecting improved access to culturally appropriate care and communication.

Area of Opportunities:

Safety and Effective Care

- *Fall Rate- Target 12, achieved 15.4; Falls with injury- Target 2, achieved 6.7*
  - Strategies:
    - Reinforce purposeful rounding 4 P's: pain, personal care, position and possessions.
    - Perform regular environmental safety checks to identify and address fall risks (e.g., clutter, poor lighting).
    - Engage patients and families in fall prevention education and safety planning.
- *Incidents of Restraint use- Target 0, achieved 2.9*
  - Strategies:
    - Promote the use of alternative, least-restrictive interventions through de-escalation techniques, environmental modifications, and increased patient engagement.
    - Educate staff on clinical decision-making around restraint use, emphasizing patient dignity, safety, and documentation of all attempted alternatives.
    - Ensure patient safety remains a top priority when restraints are necessary, with frequent monitoring, reassessment, and timely removal as appropriate
- *Order set use COPD- Target 90%, achieved 26.1%*
  - Strategy: Focus on provider motivation, accountability and workflow integration
    - Promote accountability and normalize order set use through data transparency, sharing best practices, and creating a sense of collective ownership toward meeting the 90% target.
    - Conduct targeted feedback sessions with physicians to identify specific barriers to order set use such as workflow misalignment, content concerns, or time constraints.
- *Pressure injury development during inpatient stay- Target of 0 incidents, achieved 2*
  - Strategy: Continued focus on daily skin assessments and repositioning protocols with staff education and real-time monitoring to proactively prevent pressure injuries.
- *Hand Hygiene compliance rate (Moment 1)- Target >92%, achieved 75.7%*

- Strategy:
  - Ongoing reminders to staff about key hand hygiene moments and fostering a culture of accountability through regular monitoring and feedback.
  - Engaging each department to take on the role of internal auditors for hand hygiene compliance, promoting shared responsibility and reinforcing a sense of organizational ownership.

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.

HÔPITAL Glengarry Memorial HOSPITAL

Clinical Quality and Safety Dashboard

Fiscal 2024/25

THEME	METRIC	MEASUREMENT	REPORT SOURCE	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	90th percentile emergency department wait time to inpatient bed	Number of hours	Manager, HIS	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	3.3	4.8	2.8	3.6	3.1
Experience	Turnover Rate (% of nursing staff who left the organization voluntarily or involuntarily		Chief, Human Resources	5.6%	5.0%	3.8%	0.0%	6.3%	10.0%	0.0%	1.2%	1.2%	2.4%	0.0%	1.2%	1.1%	2.5%	0.0%	1.3%	1.3%	2.5%	1.4%
	Nursing - % Paid Overtime Hours		Manager, Finance	18.7%	17.0%	18.8%	10.4%	9.3%	12.4%	14.3%	14.2%	17.0%	15.2%	15.6%	10.7%	16.7%	13.9%	10.6%	13.3%			13.4%
	Percent of respondents answering yes to the question "did you participate in your plan of care?"	% of those who answered Positively/total surveys	Manager, HIS	78.0%	80.0%	96.2%	93.1%	97.0%	95.4%	96.8%	96.0%	96.3%	96.3%	91.5%	92.5%	92.2%	92.1%	95.7%	95.2%	96.3%	95.7%	94.9%
	Percent of respondents answering yes to the question "were you involved as much as you wanted to be in decisions about you or your family member's care and treatment?"	% of those who answered Positively/total surveys	Manager, HIS	85.0%	87.0%	97.4%	99.2%	100.0%	98.7%	96.3%	97.0%	98.3%	97.3%	95.9%	85.9%	80.9%	87.4%	96.5%	97.8%	99.3%	97.8%	94.9%
Safety	Fall Rate	# of incidents per 1000 patient days	Manager, HIS	13.0	12.0	16.3	7.5	13.7	12.5	12.2	30.2	15.3	19.9	12.6	8.8	8.0	9.8	13.0	12.4	21.3	15.4	14.2
	Falls with injury (any fall requiring intervention or treatment)	# of incidents per 1000 patient days	Manager, HIS	2.00	2.00	4.67	2.49	4.57	3.89	4.59	8.46	3.82	5.74	6.86	1.10	2.29	3.39	3.56	8.71	8.00	6.68	4.88
	Incidents of Physical Violence	Actual Number	Manager, HIS	84	75	2	0	3	5	0	0	0	0	2	0	3	5	2	2	3	7	17
	Incidents of Restraint use	Actual Number	Manager, HIS	0.00	0.00	0.00	0.00	1.00	1.00	0.00	1.00	1.00	2.00	0.00	0.00	1.00	1.00	2.37	6.22	0.00	2.92	1.14
	% of Patients receiving appropriate transfusion (HGB <=80)	Number of patients transfused with HgB <=80/ number of inpatient transfusions	Manager, EORLA	69.0%	75.0%	100.0%	100.0%	66.7%	83.3%	100.0%	83.3%	66.7%	77.8%	75.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	90.4%
	Assess functional decline using the Clinical Frailty Assessment on Medicine patients over the age of 64 (measured on admission/discharge)	Clinical Frailty Assessment done (both on admission and discharge)/ total admitted patients over 64	Manager, HIS	0	80.0%	87.5%	92.3%	105.9%	94.7%	73.3%	94.6%	76.3%	81.9%	77.1%	70.6%	94.3%	80.8%	81.8%	80.0%	78.8%	80.3%	84.5%
	Medication Errors (reaching the patient secondary to wrong drug/dose/patient)	Actual Number	Manager, Pharmacy Operations	59	52	0	2	5	7	6	4	5	15	5	3	3	11	8	1	2	11	44
	% of patients receiving appropriate VTE prophylaxis		Manager, Pharmacy Operations		98.0%	100.0%	100.0%	100.0%	100.0%	97.0%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%
	Orderset use COPD		Manager, HIS	0	90.0%	20.0%	14.3%	0.0%	15.4%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	20.0%	21.4%	9.1%	50.0%	33.3%	26.1%	19.6%
	Pressure injury development rate (stage 2,3,4) during inpatient stays	Actual Number	Manager, HIS	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	2	0	2	3
	Hand hygiene compliance rate (Moment 1)	# compliant activities / # of indicated activities	Manager, Professional Practice	79.0%	92.0%	75.0%	66.0%	69.0%	70.0%	84.0%	81.0%	84.0%	83.0%	67.0%	72.0%	82.0%	73.7%	86.0%	76.0%	65.0%	75.7%	75.6%
	Hand hygiene compliance rate (Moment 4)	# compliant activities / # of indicated activities	Manager, Professional Practice	88.0%	92.0%	78.0%	80.0%	93.0%	83.7%	95.0%	99.0%	98.0%	97.3%	96.0%	96.0%	98.0%	96.7%	99.0%	92.0%	96.0%	95.7%	93.3%
	C. difficile rate	# of incidents per 1000 patient days	Manager, Professional Practice & IPAC	0.30	0.00	2.33	0.00	0.00	0.86	0.00	1.21	0.00	0.44	0.00	0.00	1.14	0.38	0.00	0.00	1.33	0.42	0.52
	VRE Rate	# of incidents per 1000 patient days	Manager, Professional Practice & IPAC	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	MRSA/ ESBL Rate	# of incidents per 1000 patient days	Manager, Professional Practice & IPAC	0.40	0.00	0.00	1.25	1.52	0.86	0.00	0.00	0.00	0.00	1.14	0.00	0.00	0.38	3.56	0.00	0.00	1.25	0.62
Equity	Translation Services Usage	Actual Number in Minutes	Manager, Finance	0.00	50.00	0.0	4.0	0.0	4.0	58.0	31.0	9.0	118.0	38.0	11.0	0.0	49.0	0.0	284.0	9.0	293.0	464.0

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: May 2, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Patient Satisfaction Surveys Q4

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

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

PURPOSE

- Highlight top satisfaction indicators and identify areas for improvement to guide targeted service enhancements.
- In alignment with Accreditation standards, our team has enhanced the patient satisfaction survey to include ratings for gender diverse care, sexual orientation-related care, racialized care, and First Nations care, reflecting a deeper commitment to equity and inclusion.
- These updates enable us to better understand and respond to the expressed needs and diverse experiences of our clients, guiding more responsive, culturally safe, and community-informed service design.

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

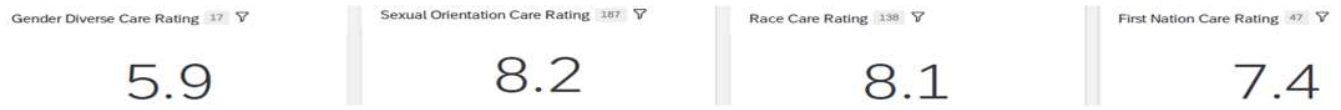
ANALYSIS

EMERGENCY DEPARTMENT- *1589 respondents*

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

Quarterly Dashboard 1,589

	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Care Rating	7.7	8.3	8.3	8.5
I did not have a long wait	52%	62%	58%	64%
During the visit, were you told the reason for the long wait?-1 to 3	24%	31%	25%	28%
Do you feel that there was good communication about your care between doctors?-1 to 4	95%	96%	96%	99%
How often did care providers treat you with courtesy and respect?	99%	99%	99%	99%
How often did care providers explain things in a way you could understand?	96%	98%	98%	98%
Did you get the emotional support you needed to help you with any anxieties?	86%	89%	91%	90%
Did care providers do everything they could to ease your discomfort?	86%	88%	90%	92%
Did you participate in your plan of care?-1 to 3	89%	93%	92%	96%



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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 = 8.5
- Communication about patient care between doctors = 99%
- Explanation of things that patients can understand = 98%
- Treated patients with courtesy and respect = 99%
- Patient participated in their plan of care = 96%

Improvement Opportunities

- Overall care rating is high, with a score of 8.5, suggesting a generally positive experience among most patients.
- Care for diverse gender patients is rated significantly lower at 5.9, highlighting a concerning gap in inclusivity, cultural competence, or perceived respect and safety.
- First Nations patient care is rated at 7.4, which is lower than the overall rating but notably higher than the rating for gender diverse care that indicates some progress, yet still an area needing targeted improvement.

Strategy:

- Disparities in care suggest systemic issues in how equitable and culturally safe the ED environment feels for marginalized groups.
- Cultural Safety and Gender Sensitivity training-These results point to a need for staff training in gender diversity and Indigenous cultural safety, along with community consultation to better address unmet needs.
    - Cultural safety- staff to understand the impacts of history, practice trauma-informed care, communicate in respectful and culturally appropriate ways (e.g. open-ended questions, being comfortable with silence which can be a sign of respect or thoughtful listening in many First Nations cultures).
    - Gender sensitivity awareness- pronoun use, respectful interaction and reducing bias.

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INPATIENT REHAB UNIT- *43 respondents*

Quarterly Dashboard

	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Care Rating	9.8	8.8	9.8	8.9
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%	64%
Friends/ family involvement	80%	83%	100%	87%

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 = 8.9
- Sexual orientation/First Nation/ Race care ratings are equal to or above 90%
- Communication about patient care between healthcare providers = 100%
- Received enough information from hospital staff = 100%
- Friends/family involvement in the patient's rehabilitation journey = 87%

Improvement Opportunity

- Patient's active involvement during the rehabilitation journey = 64%
- Gender care rating 8.0 which is lower than the overall care rating of 8.9

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.
- **Equitable, gender-sensitive care**- implementation of gender sensitivity and inclusivity training including topics such as respectful language, pronoun use and unconscious bias.

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OUTPATIENT DEPARTMENT- *251 respondents*

Quarterly Dashboard 251

	Q1 2025	Q2 2025	Q3 2025	Q4 2025
Overall Care rating	9.2	9.5	9.7	9.3
If you had a long wait, were you told the reason why	18%	21%	23%	29%
Got the appointment in 6 weeks or less	80%	72%	79%	80%
Appointment Wait Time <15 mins	88%	97%	95%	93%
Did you feel like the healthcare providers worked together?	95%	100%	97%	98%
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%	97%

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 = 9.3
- Sexual orientation care 8.9, Gender Diverse/Race/First Nations care rating equal to or greater than 90%
- Patient appointment's wait time is less than 15 minutes = 93%
- Patients got the appointment in 6 weeks or less = 80%
- Patients felt the healthcare providers worked together = 100%
- 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 = 29%

Strategies

- Communication- continue to remind staff to proactively inform patients about delays and provide updates on expected wait times during appointments.

Summary

Q4 patient satisfaction survey results indicate overall positive experiences with care delivery; however, feedback highlights the need for enhanced inclusivity and cultural safety. In response, future quality improvement efforts will prioritize care tailored to gender-diverse individuals, inclusive of sexual orientation, racialized communities, and First Nations populations. The focus will be on creating affirming, equitable, and culturally responsive care environments to better meet the diverse needs of our patients.

DECISION SUPPORT DOCUMENT FOR

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

☐ Other *(please specify):*

Date Prepared: May 6, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Violent Incidents Q4

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

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

PURPOSE

- Provide an update for Q4 and the measures taken to mitigate and address these incidents.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

SITUATION & BACKGROUND

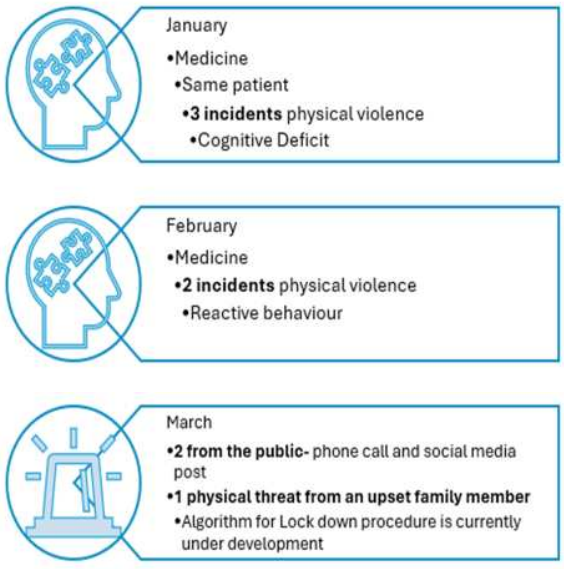
A brief description of the background to the issue.

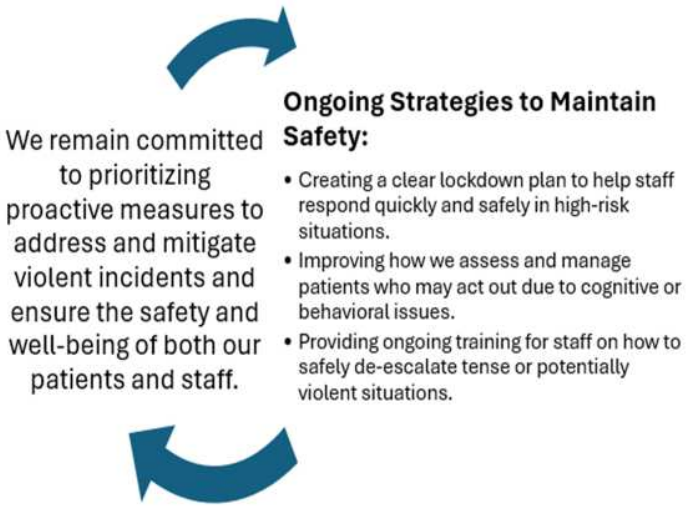
- Violence within healthcare settings is a concern, impacting the safety and well-being of both our staff and patients.
- Understanding root causes of these incidents is crucial to implementing effective preventative measures.

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.

A total of 7 violent incidents were reported in Q4.





DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: April 15, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Complaints and Compliments Q4

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

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

PURPOSE

- Review the complaints and compliments for Q4 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:*

SITUATION & BACKGROUND

A brief description of the background to the issue.

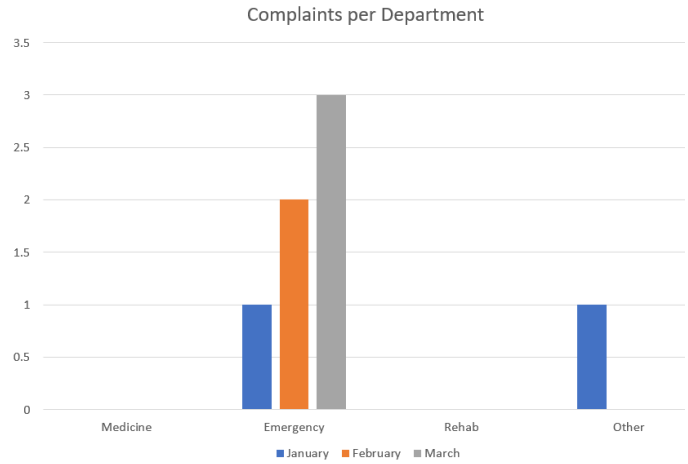
- Reviewing complaints and compliments is a crucial component of our commitment to transparency, continuous improvement, and patient centered care.
- A summary of the complaints and compliments received will be reviewed at Internal Quality and brought to Board Quality quarterly to keep the committee 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

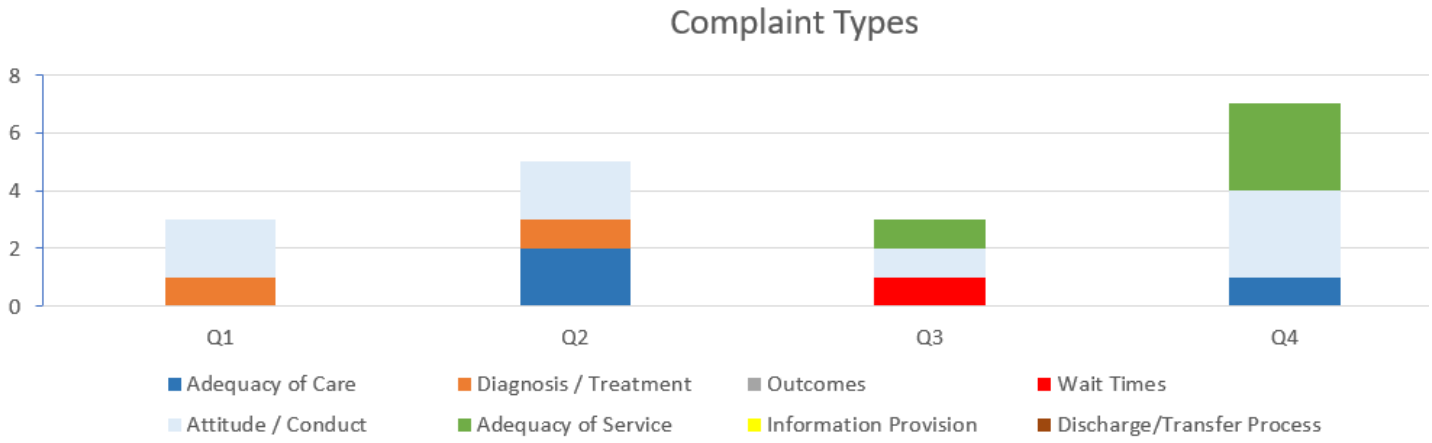
Outline both the positive and negative consequences of the recommendations in terms of financial, mission, quality, risk and other.

Complaints:

- In Q4, HGMH saw 4,575 patients in the emergency department.
- There was a total of 7 formal complaints received, mostly within the Emergency Department.

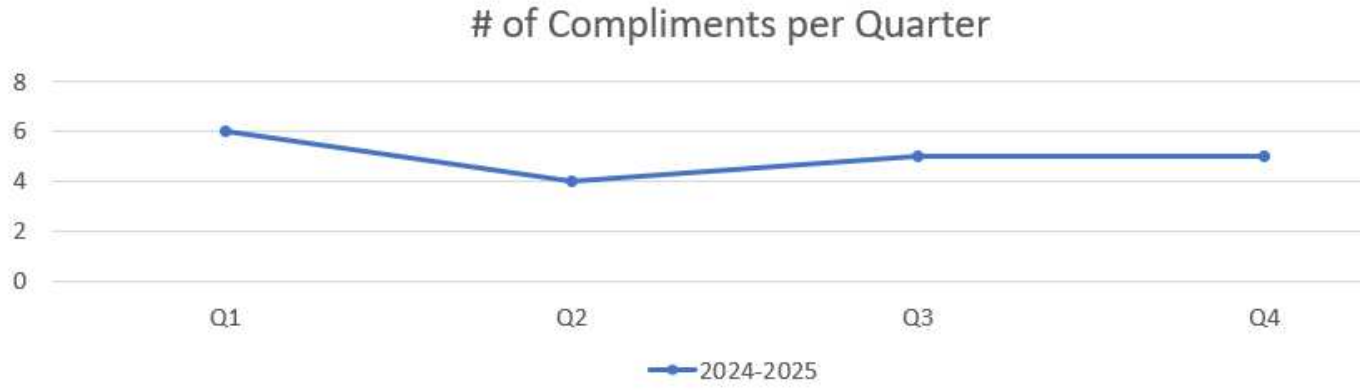


- The complaints received were all around the adequacy of service and attitude/conduct of both nursing staff and physicians.



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.



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 our Patient Rights and Responsibilities on the walls and tv screens in waiting rooms.

DECISION SUPPORT DOCUMENT FOR

☐ Board of Directors ☒ Board Committee – Quality and Patient Safety ☐ Senior Leadership Team

☐ Other *(please specify):*

Date Prepared: May 5, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Quality Review Recommendations

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

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

PURPOSE

- To update the Board on recommendations arising from a quality review and focusing on improvements to patient-centred care, safety protocols, and interprofessional communication within clinical areas.

RECOMMENDATION / MOTION

- That the Board acknowledge the ongoing implementation of these initiatives and support their continued rollout and monitoring to strengthen care quality, safety standards, and staff accountability.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- Quality & Safety dvisory Committee

IMPACT ANALYSIS/RISK ASSESSMENT/DECISION CRITERIA

- A series of initiatives have been launched following a quality review to strengthen patient-centred care, safety, and clinical accountability. These efforts include improving communication among care teams, standardizing emergency preparedness practices, and reinforcing documentation standards and privacy protocols. Collectively, these actions aim to enhance care quality, ensure staff readiness, and support a safe and respectful environment for patients and families.

SUPPORTING DOCUMENTS/ATTACHMENTS- Sample Quality Review Action Plan

Action Plan- Summary of Recommendations

	Check if applicable	Action Item details	Owner	Due Date	Comments
Education	☐				
Presentation	☐				
Internal Investigation	☐				
External Investigation	☐				
Report submitted to Board Quality Committee	☐				
Report submitted to Quality and Safety Advisory Committee	☐				
Report submitted to Medical Advisory Committee	☐				

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 6, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Kids Come First Regional Peadiatric Surgery Update

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- To provide the Board of Directors with an update on the expansion proposal submitted through the Kids Come First (KCF) Health Team to enhance pediatric surgical capacity in Eastern Ontario, and to outline Hôpital Glengarry Memorial Hospital's (HGMH) participation in this regional collaboration.

RECOMMENDATION / MOTION

That the Quality & Patient Safety Committee review and receive this update for information and continue to endorse HGMH's participation in the Kids Come First Health Team's efforts to regionalize pediatric surgical care.

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 Kids Come First Health Team is a formal Ontario Health Team that includes over 60 health and community partners committed to improving care for children and youth across Eastern Ontario.
- HGMH is a member of the KCF Health Team. CHEO, on behalf of the KCF partners, submitted a funding proposal to expand the Regional Pediatric Surgical Program.
- The proposal outlines a model to address the significant backlog of pediatric surgeries through a regional hub-and-spoke model leveraging regional hospital OR capacity and coordinated clinical and logistical support from CHEO.

OPTIONS CONSIDERED & ANALYSIS

Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.

- Three operational models were evaluated: a centralized CHEO-led model, a distributed funding model, and stand-alone pediatric capacity at partner sites.
- The proposed model is a hub-and-spoke framework led by CHEO, coordinating surgical delivery across partner hospitals. This model has demonstrated early success through pilot sites at Carleton Place and Brockville.
- The preferred model was selected based on its scalability, patient-centred benefits, operational feasibility, and alignment with existing clinical partnerships.

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

- This regional strategy will increase pediatric surgical capacity by 1,000–1,200 procedures annually, improving access to timely care for children and reducing burdens on families.
- Risks include limited funding availability, gaps in pediatric surgical/anesthesia HHR, and insufficient pediatric infrastructure at regional hospitals.
- The model addresses these risks by providing shared CHEO support staff, centralized coordination, training, and supply logistics. However, the program remains contingent on the approval of submitted funding.

CONSULTED WITH:

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

- CHEO,
- Ontario Health East,
- Cornwall Community Hospital,
- Brockville General Hospital,
- Pembroke Regional Hospital, Hawkesbury & District General Hospital, and additional partner hospitals.
- HGMH participated in the KCF Regional Pediatric Surgery Program Working Group.

IMPLEMENTATION & COMMUNICATION PLAN

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

- CHEO will act as the central hub, coordinating pre-operative assessments, OR time, and clinical support at regional sites.
- HGMH remains committed to participating in the collaborative model, as we look to build out our surgical program following the EPIC go live.
- The proposal has been submitted; however, no confirmation of funding has been received to date. Updates will be communicated as more information becomes available.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 6, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Surgical Expansion Options Analysis Overview

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

To present the findings of the Surgical Operating Room (OR) Review and provide a recommended strategic direction for expanding surgical services at Hôpital Glengarry Memorial Hospital (HGMH), while also outlining the rationale for deferring immediate expansion given the organization's current investment in the EPIC Electronic Medical Record (EMR) implementation.

RECOMMENDATION / MOTION

That the Quality & Patient Safety Committee review and receive the Surgical Expansion Options Analysis Overview and support a phased advancement of surgical expansion opportunities, recognizing that implementation will be sequenced following the EPIC EMR go-live and stabilization period, and integrated with the future deployment of EPIC's surgical module.

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.

HGMH currently operates a single surgical OR that is underutilized, offering a limited mix of day procedures including endoscopy, minor urology, and general 'lumps & bumps' surgeries. Recognizing both an opportunity and an imperative to increase access to care closer to home, HGMH assessed the viability of expanding surgical services across seven specialty areas. This included analysis of demand, funding alignment, infrastructure requirements, and human resource capacity.

OPTIONS CONSIDERED & ANALYSIS

Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.

The assessment examined seven surgical options:

- Endoscopy,
- General Surgery,
- Gynecology,
- Ophthalmology,
- Orthopedics,
- Urology, and
- Pediatrics.

Each was scored using a structured framework across four weighted dimensions:

- Accessible Market,
- Funding Opportunities,
- Equipment Needs, and
- Resourcing Requirements.

- Endoscopy and Ophthalmology emerged as the highest priority options in the short term.
- Medium-term opportunities include Gynecology and Urology.
- Orthopedics and Pediatrics being longer-term prospects contingent on the availability of general anesthesia.
- No viable alternatives to surgical expansion were identified that meet current community needs.

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

Positive impacts of surgical expansion include enhanced access to surgical services, reduced regional wait times, improved patient satisfaction, and increased use of existing OR assets.

Financially, there is potential for revenue growth through quality-based procedures and partnership-based models. However, a key consideration is the concurrent organizational focus on the EPIC EMR transition, which demands substantial clinical and operational resources. It is not advisable to implement additional Meditech surgical modules at this time, given the redundancy and cost inefficiency of transitioning EMRs.

Aligning surgical expansion with the future deployment of the EPIC surgical module will allow for improved integration, workflow optimization, and reduced risk to service delivery.

CONSULTED WITH:

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

- HGMH Surgeons and Clinical Leaders,
- Ontario Health,
- Children's Hospital of Eastern Ontario (CHEO),
- Cornwall Community Hospital,
- Hawkesbury General Hospital, and
- Haldimand War Memorial Hospital.

IMPLEMENTATION & COMMUNICATION PLAN

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

In the short term, preparatory work such as business case development for ophthalmology and high-level equipment planning for gynecology and urology will proceed. Operational expansion will be deferred until after EPIC go-live in 2026 to ensure organizational capacity and allow for integration of the EPIC surgical module. Internal communications will emphasize the importance of sequencing these transformational initiatives strategically to ensure sustainable implementation.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: April 1, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Quality & Patient Safety Framework

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

- The purpose of this briefing note is to provide the Board of Directors with an overview of the development of a Quality and Patient Safety Policy and Framework for Hôpital Glengarry Memorial Hospital (HGMH). This policy and framework will define the hospital's commitment to quality, and align with Accreditation Canada requirements to ensure continuous quality improvement and patient safety.

RECOMMENDATION / MOTION

- THAT the Quality & Patient Safety Committee recommend to the Board of Directors the approval and implementation of the Quality and Patient Safety Framework as presented.
- This policy will establish a clear definition of quality, outline the hospital's quality framework, and formalize the Board's oversight responsibilities to ensure compliance with national standards and best practices.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

- Resources & Finance Committee
- Governance & Nominating Committee

SITUATION & BACKGROUND

A brief description of the background to the issue.

- HGMH is committed to delivering high-quality, safe, and patient and family centered care. As part of its governance responsibilities, the Board must provide strategic oversight of quality and safety initiatives within the organization. A formalized policy and framework will ensure that quality and safety remain a top priority and that there is a structured approach to achieving excellence in healthcare delivery.
- Accreditation Canada outlines specific requirements related to quality and patient safety under its Governance Standards. These include ensuring that the Board has a clear definition of quality, an established quality framework, and the necessary structures and processes to monitor and improve care. Without a formal policy in place, there is a risk that quality and patient safety efforts may lack cohesion and strategic alignment.
- Healthcare organizations are required to maintain rigorous quality and patient safety standards to meet both regulatory and accreditation requirements. Accreditation Canada's Governance Standards specify that hospital boards must:
    - Define quality and have a quality framework that guides decision-making and improvement initiatives.
    - Ensure structures and processes are in place to monitor and enhance the quality and safety of care.
    - Regularly review quality and patient safety performance indicators.
    - Foster a culture of quality and safety across the organization.

- The proposed Quality and Patient Safety Policy and Framework will incorporate the key dimensions of quality as defined by Health Quality Ontario, including safe, effective, patient centred, efficient, timely, and equitable. Additionally, it will align with the Canadian Quality & Patient Safety Framework for Health Services to ensure a nationally recognized approach to quality governance.
- By approving this policy and framework, the Board will strengthen its governance role in quality and patient safety, ensuring HGMH meets accreditation requirements and maintains excellence in healthcare governance.
- If approved, this policy will be added to the Governance Policy Manual for regular review and included on the Board Portal.

CONSULTED WITH:

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

- Patient & Family Advisory Committee
- Quality and Safety Advisory Committee
- Rachel Romany, Vice President of Clinical Services, Quality, & Chief Nursing Executive

IMPLEMENTATION & COMMUNICATION PLAN

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

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Quality & Patient Safety Framework

Document Name:	Quality & Patient Safety Framework	
Document Number:	BOD.03.005.0.25	
Review Period:	☒3 years ☐1 year	**Manual:** Governance Policy Manual
Classification: Board of Directors	**Section:** Program & Quality Effectiveness	
Owner: President & CEO	**Signing Authority:** Board of Directors	

POLICY STATEMENT:

The Board is accountable for ensuring that the hospital establishes a clear definition of quality and adopts a quality framework to guide all activities related to the quality of care provided by the organization. This includes implementing appropriate structures, processes, and systems to support its responsibility for quality. Additionally, the Board must continuously monitor and exercise oversight of these frameworks and mechanisms to ensure they effectively uphold and enhance the delivery of safe, high-quality care.

DEFINITIONS:

Quality: For Hôpital Glengarry Memorial Hospital (HGMH), quality means delivering safe, effective, patient centered, efficient, timely, and equitable services resulting in optimal patient health outcomes, guided by Health Quality Ontario's definition of a high-quality health system. The following chart outlines these key dimensions, detailing what each element means from both the patient's perspective and the provider's perspective. This dual approach ensures that quality improvement efforts align with patient needs while supporting providers in delivering safe, effective, and compassionate care.

Element	Patient meaning	Provider meaning
Safe	*I will not be harmed by the health system*	*The care my patient receives does not cause the patient to be harmed*
Effective	*I receive the right treatment for my condition, and it contributes to improving my health*	*The care I provide is based on best evidence and produces the desired outcome*
Patient Centered	*My goals and preferences are respected. My family and I are treated with respect and dignity*	*Decisions about my patient's care reflect the goals and preferences of the patient and their family or caregivers*
Efficient	*The care I receive from all practitioners is well coordinated and efforts are not duplicated*	*I deliver care to my patients using available human, physical, and financial resources efficiently, with no waste to the system*
Timely	*I know how long I have to wait to see a doctor or for tests or treatments I need and why. I am confident this wait time is safe and appropriate*	*My patient can receive care within an acceptable time after the need is identified*
Equitable	*No matter who I am or where I live, I can access services that benefit me. I am fairly treated by the organization and health care system*	*Every individual has access to the services they need, regardless of his or her location, age, gender, or socio-economic status*

Quality Framework: The quality framework serves to ensure alignment and accountability for quality through the hospital, and has been adopted from the Canadian Quality & Patient Safety Framework for Health Services.

The Framework's ultimate aims are:

1. Improving key quality and safety areas
2. Reducing unwarranted care variation
3. Strengthening high-quality health services that improve patient experiences and outcomes

The Board of Directors will apply this framework to guide the activities related to quality of care provided by HGMH. The following framework defines five goal areas designed to drive improvement and to align Canadian legislation, regulations, standards, organizational policies and public engagement on patient safety and quality improvement.

Goal 1 | People-Centred Care
People using health services are equal partners in planning, developing, and monitoring care to make sure it meets their needs and to achieve the best outcomes.

Goal 2 | Safe Care
Health services are safe and free from preventable harm.

Goal 3 | Accessible/Timely/Equitable Care
People have timely and equitable access to quality health services.

Goal 4 | Appropriate/Effective/Efficient Care
Care is evidence-based and people-centred.

Goal 5 | Integrated Care
Health services are continuous and well-coordinated, promoting smooth transitions.

PROCEDURE:

HGMH is committed to delivering high-quality, safe, and patient-centered care in alignment with the Canadian Quality & Patient Safety Framework for Health Services. This framework establishes five key goals to guide healthcare organizations in achieving excellence in quality and patient safety, which are:

- People-Centered Care
- Safe Care
- Accessible Care
- Appropriate Care
- Integrated Care

The Board of Directors plays a critical role in ensuring these principles are embedded in the organization's governance, strategic direction, and operational oversight.

To uphold ***People Centred Care***, the Board will:

- Set the expectation that the organization ensures patients and families have the information they need to make informed decisions about their care, improving patient experiences and outcomes.
- Ensure diverse populations, including Indigenous, Black, LGBTQ2S+, immigrant, and rural communities, receive culturally safe care by embedding respect for culture, values, and beliefs into strategic planning and policy development.
- Support and promote formal and informal partnerships with patients and healthcare providers to enhance service delivery and patient engagement.
- Regularly review patient-reported experience and outcome measures to assess whether hospital services are making a meaningful, positive impact on patient care and overall health outcomes.

To advance ***Safe Care***, the Board will:

- Ensure accountability for patient safety by overseeing that safety concerns and incidents are appropriately addressed.
- Support a psychologically and physically safe work environment by ensuring healthcare providers have access to staff wellness and retention programs.
- Regularly review safety outcomes and reported trends to proactively drive improvements in safe practices.
- Ensure the organization participates in accreditation processes where applicable, reinforcing a commitment to continuous quality and safety improvement.

To enhance ***Accessible Care***, the Board will:

- Ensure that diverse populations, including Indigenous, Black, LGBTQ2S+, immigrant, and rural communities, receive safe, equitable, and timely care by addressing barriers to access.
- Develop and implement needs-based human resource allocation strategies to ensure appropriate staffing levels and service availability that meet the needs of the communities served.

To ensure ***Appropriate Care***, the Board will:

- Encourage health promotion and disease prevention initiatives to improve overall community well-being.
- Ensure infrastructure and accountability measures are in place to support seamless care transitions across health services, particularly between urban, rural, and remote settings.
- Ensure health teams, including patients and families, have appropriate access to integrated electronic health records to enhance care coordination and decision-making.

REFERENCES:

1. Healthcare Excellence Canada. (2020). *Canadian Quality & Patient Safety Framework for Health Services*.
2. Health Quality Ontario. (2017). *Quality Matters: Realizing Excellent Care for All*.

APPENDIX A Activities the Board Undertakes to Support the Quality & Safety Framework	
People Centred	• Set expectations for active patient engagement throughout our organization. • Review patient experience data along with quality and patient safety action plans. • Regularly review patient feedback and learn about patient experiences through the use of patient stories at the Board. • Develop organizational policies, an Inclusion, Diversity, Equity, and Anti-Racism (IDEA) framework, and appropriate measures for addressing anti-racism, cultural safety and humility, in collaboration with diverse peoples. • Support and participate in anti-racism, cultural safety and humility training for board members and all staff. • Encourage membership of diverse peoples, including Indigenous, Black, LGBTQ2S+, immigrant, and people in rural and remote communities on the board. • Commit to establishing relationships with the communities our organization serves. • Establish mechanisms to engage with the Patient & Family Advisory Committee to incorporate their voices and perspectives in board initiatives. • Develop organizational strategic plans in collaboration with patient partners. • Include patient and family representative membership on our board and/or board committees. • Educate the Board about patient experience and outcome measures as part of our onboarding process. • Review qualitative and quantitative data about patient and staff experiences. • Seek updates from the patient and family advisory committee. • Provide feedback on targets, outcome indicators, and actions for improvement. • Review and approve quality, patient safety, and strategic plans.
Safe Care	• Prioritize quality and patient safety on the board's agenda. • Review reports on patient safety, recommended actions arising out of patient safety incident analyses, and resulting action plans for improvements. • Demonstrate accountability for our organization's quality and safety goals. • Foster psychological support programs for the health team. • Ensure that the health team is aware of available psychological support programs, turnover rates, and plans for improvement. • Review workplace health and safety information, turnover data, absenteeism rates, and mental health and workplace violence claims and use this information to assess improvement plans. • Review data on avoidable deaths and the implementation of relevant evidence-based practices. • Allocate resources for training, implementing evidence-based practices, and measuring outcomes. • Ensure actions are taken to improve patient outcomes. • Participate in accreditation for our organization and professionals. • Review the accreditation report and monitor actions that arise from it. • Share accreditation results internally and publicly. • Establish a process for publicly reporting data on patient harm and other indicators that reflect organizational safety.
Accessible Care	• Collect and review population data and consider the needs of diverse peoples in your strategic planning. • Identify health services that are monitored for access and review data on wait times to increase access to services. • Ensure that targets for access to services are measured and publicly reported and that actions are taken to drive improvement. • Ensure best practice for human resource strategic planning. • Evaluate the impact of human resource allocation decisions on quality, safety, and patient experience.

Appropriate Care	• Review population health outcomes and your organization's action plans for promoting health and preventing disease. • Participate in education on disease prevention and screening interventions and innovations.
Integrated Care	• Understand the challenges and solutions for electronic health record management and allocate resources for information systems implementation and improvement. • Advocate for an electronic health record to connect patients and providers and to give patients direct access to their personal health information.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 6, 2025 Meeting Date Prepared for: May 14, 2025

Subject: HIROC Claims History

Prepared by: Robert Alldred-Hughes, President & CEO

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

PURPOSE

The purpose of this briefing note is to provide an overview of historical insurance file claims submitted to the Hospitals Insurance Reciprocal of Canada (HIROC) and to outline why the Board of Directors is reviewing this information.

RECOMMENDATION / MOTION

THAT the Quality & Patient Safety Committee review and receive the Hospitals Insurance Reciprocal of Canada historical claims submission.

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.

- Hôpital Glengarry Memorial Hospital (HGMH) has a longstanding relationship with HIROC, our insurance provider.
- Over the years, HGMH has submitted numerous insurance claims for incidents ranging from professional liability to property damage.
- As part of our ongoing commitment to quality improvement and risk management, the Board of Directors conducts a thorough review of our historical insurance file claims.
- This review aims to identify trends, patterns, and areas for improvement in our operations, patient care, and risk mitigation strategies. By analyzing past claims data, we can gain valuable insights into potential areas of vulnerability and take proactive measures to prevent future incidents.

OPTIONS CONSIDERED & ANALYSIS

Outline alternatives that were contemplated in coming to a recommendation. If no viable alternatives exist, include that information as well.

- HGMH conducts quality reviews related to critical events, or events involving the care of our patients where there is opportunity to learn. These reviews can also lead to root cause analysis, risk assessments, and actions plans.
- When a Quality Review is conducted by the care team, the recommendations do come to the Quality Committee of the Board for awareness.
- In addition, reviewing claims history can help with identification of trends which analyze the frequency and nature of past insurance claims to identify any recurring patterns or trends. This may include common types of incidents, departments or areas most frequently involved, and contributing factors such as human error or

system failures. Upon review of the most recent history, there has not been any trends identified, as the one submissions do not have common factors, nor do the submissions from recent years.

- By conducting this comprehensive review of our historical insurance file claims, we can enhance our risk management practices, improve patient safety, and ultimately enhance the overall quality of care provided at HGMH.

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- HIROC Claims Audit Report

Claims Audit Report

Accounting Date As Of: 31-Mar-2025

Glengarry Memorial Hospital - 107254

Risk Name	Claim No	Coverage	Policy Year	Date of Loss	Date Reported	Indemnity Paid	Expense Paid	Total Paid	Reserved	Total Incurred	Date Closed	Claim Status	Claim Type
Glengarry Memorial Hospital	254-10552	A:Bodily Injury	2006	04-Nov-2006	20-Nov-2006	$0.00	$2,006.57	$2,006.57	$0.00	$2,006.57	18-Dec-2007	CLOSED	Claim
Glengarry Memorial Hospital	254-11512	C: Prof Liab	2008	17-Jan-2006	05-Feb-2008	$0.00	$42,159.09	$42,159.09	$0.00	$42,159.09	05-Jul-2012	CLOSED	Suit
Glengarry Memorial Hospital	254-11711	C: Prof Liab	2008	07-Mar-2008	07-May-2008	$0.00	$431.60	$431.60	$0.00	$431.60	09-Jul-2009	CLOSED	Claim
Glengarry Memorial Hospital	254-12024	A:Bodily Injury	2008	28-Aug-2008	22-Sep-2008	$0.00	$1,737.96	$1,737.96	$0.00	$1,737.96	25-Nov-2009	CLOSED	Claim
Glengarry Memorial Hospital	254-12247	B:Property Dam.	2008	31-Dec-2008	06-Jan-2009	$634.13	$863.96	$1,498.09	$0.00	$1,498.09	17-Dec-2009	CLOSED	Claim
Glengarry Memorial Hospital	15548-01	C: Prof Liab	2009	03-Aug-2008	10-Nov-2009	$0.00	$5,259.91	$5,259.91	$0.00	$5,259.91	19-Jan-2011	CLOSED	Claim
Glengarry Memorial Hospital	254-13007	C: Prof Liab	2009	27-Dec-2007	30-Oct-2009	$0.00	$43,300.67	$43,300.67	$0.00	$43,300.67	27-Jul-2015	CLOSED	Suit
20260 County Road 43	15070-01	C: Prof Liab	2010	12-Jan-2010	13-Jan-2010	$0.00	$1,683.64	$1,683.64	$0.00	$1,683.64	07-Jan-2011	CLOSED	Claim
20260 County Road 43	16296-01	C: Prof Liab	2010	07-Oct-2010	13-Oct-2010	$0.00	$1,935.36	$1,935.36	$0.00	$1,935.36	28-Nov-2011	CLOSED	Claim
20260 County Road 43	17374-01	C: Prof Liab	2011	03-Feb-2009	07-Jun-2011	$0.00	$40,435.83	$40,435.83	$0.00	$40,435.83	17-Oct-2014	CLOSED	Suit
20260 County Road 43	18346-01	D:Conting.Empl.	2011	30-Sep-2011	16-Dec-2011	$0.00	$5,610.62	$5,610.62	$0.00	$5,610.62	26-Mar-2013	CLOSED	Suit
20260 County Road 43	20824-01	C: Prof Liab	2013	31-May-2013	03-Jun-2013	$0.00	$4,231.78	$4,231.78	$0.00	$4,231.78	30-Jan-2014	CLOSED	Claim
Glengarry Memorial Hospital	20831-01	A:Bodily Injury	2013	03-Jun-2013	04-Jun-2013	$0.00	$5,002.00	$5,002.00	$0.00	$5,002.00	03-Nov-2014	CLOSED	Claim
20260 County Road 43	22710-01	A:Bodily Injury	2014	19-Jul-2014	22-Jul-2014	$0.00	$2,146.57	$2,146.57	$0.00	$2,146.57	26-Oct-2016	CLOSED	Claim
20260 County Road 43	25260-01	C: Prof Liab	2016	02-Nov-2014	15-Jan-2016	$0.00	$2,794.43	$2,794.43	$0.00	$2,794.43	02-Jun-2017	CLOSED	Claim
20260 County Road 43	27445-01	C: Prof Liab	2017	10-Jun-2015	14-Mar-2017	$0.00	$2,549.58	$2,549.58	$0.00	$2,549.58	29-Jun-2018	CLOSED	Claim
20260 County Road 43	27806-01	C: Prof Liab	2017	12-Aug-2016	25-May-2017	$0.00	$4,224.71	$4,224.71	$0.00	$4,224.71	21-Feb-2019	CLOSED	Claim
20260 County Road 43	32563-01	C: Prof Liab	2019	30-Sep-2017	03-Sep-2019	$12,500.00	$20,493.76	$32,993.76	$0.00	$32,993.76	26-Jan-2021	CLOSED	Suit
20260 County Road 43	33454-01	C: Prof Liab	2020	07-Jan-2018	05-Feb-2020	$0.00	$45,667.46	$45,667.46	$0.00	$45,667.46	11-Oct-2023	CLOSED	Suit
20260 County Road 43	34382-01	C: Prof Liab	2020	26-Jun-2020	08-Jul-2020	$64,000.00	$7,563.42	$71,563.42	$0.00	$71,563.42	17-Mar-2022	CLOSED	Claim
20260 County Road 43	41037-01	C: Prof Liab	2023	18-Jan-2022	06-Feb-2023	$0.00	$22,943.93	$22,943.93	$22,056.07	$45,000.00		OPEN	Suit
20260 County Road 43	41242-01	C: Prof Liab	2023	03-Mar-2023	06-Mar-2023	$0.00	$4,214.10	$4,214.10	$0.00	$4,214.10	21-Mar-2025	CLOSED	Claim
20260 County Road 43	42527-01	C: Prof Liab	2023	27-Jul-2023	09-Aug-2023	$0.00	$1,720.00	$1,720.00	$0.00	$1,720.00	22-Jan-2025	CLOSED	Claim

Claims Audit Report

Accounting Date As Of: 31-Mar-2025

Glengarry Memorial Hospital - 107254

Risk Name	Claim No	Coverage	Policy Year	Date of Loss	Date Reported	Indemnity Paid	Expense Paid	Total Paid	Reserved	Total Incurred	Date Closed	Claim Status	Claim Type
20260 County Road 43	45615-01	A:Bodily Injury	2024	23-Aug-2024	09-Sep-2024	$0.00	$0.00	$0.00	$45,000.00	$45,000.00		OPEN	Claim
Total						**$77,134.13**	**$268,976.95**	**$346,111.08**	**$67,056.07**	**$413,167.15**			

Claims Audit Report

Accounting Date As Of: 31-Mar-2025

Claims Audit Report
Liability & Crime

Policy Year	Open	Closed	Total Claims	Total Reserve	Indemnity Paid (O)	Expense Paid (O)	Total Open	Total Closed	Total Incurred
2006	0	1	1	$0.00	$0.00	$0.00	$0.00	$2,006.57	$2,006.57
2008	0	4	4	$0.00	$0.00	$0.00	$0.00	$45,826.74	$45,826.74
2009	0	2	2	$0.00	$0.00	$0.00	$0.00	$48,560.58	$48,560.58
2010	0	2	2	$0.00	$0.00	$0.00	$0.00	$3,619.00	$3,619.00
2011	0	2	2	$0.00	$0.00	$0.00	$0.00	$46,046.45	$46,046.45
2013	0	2	2	$0.00	$0.00	$0.00	$0.00	$9,233.78	$9,233.78
2014	0	1	1	$0.00	$0.00	$0.00	$0.00	$2,146.57	$2,146.57
2016	0	1	1	$0.00	$0.00	$0.00	$0.00	$2,794.43	$2,794.43
2017	0	2	2	$0.00	$0.00	$0.00	$0.00	$6,774.29	$6,774.29
2019	0	1	1	$0.00	$0.00	$0.00	$0.00	$32,993.76	$32,993.76
2020	0	2	2	$0.00	$0.00	$0.00	$0.00	$117,230.88	$117,230.88
2023	1	2	3	$22,056.07	$0.00	$22,943.93	$45,000.00	$5,934.10	$50,934.10
2024	1	0	1	$45,000.00	$0.00	$0.00	$45,000.00	$0.00	$45,000.00
Total	**2**	**22**	**24**	**$67,056.07**	**$0.00**	**$22,943.93**	**$90,000.00**	**$323,167.15**	**$413,167.15**

Claim Type: Claim = non-litigated (no Statement of Claim served); Suit = litigated (Statement of Claim served)
Open claim status: includes Open, Re-open, Abeyance, Abeyance-Infant
*Total Reserve = Total Indemnity Reserve + Total Expense Reserve **
Expense Paid (O) = Paid Expense, for Open claims
Indemnity Paid (O) = Indemnity Paid, for Open claims
Total Open = Total Reserve + Paid Indemnity + Paid Expense, for Open claims
Total Closed = Total Reserve + Paid Indemnity + Paid Expense, for Closed claims
Total Incurred = Total Open + Total Closed

Report of the VP Clinical Services, Quality & Chief Nursing Executive

May 14, 2025 Board Quality and Patient Safety Committee Meeting

Patient & Family Advisory Committee (PFAC) Update

PFAC members met to plan activities for Patient Experience Week (April 28 – May 2), including Leader and PFAC patient rounding, an informational display board, and certificate distribution to recognize staff contributions to patient experience. Teams were also invited to submit group photos holding a sign that reads "*We are the patient experience*".

Although PFAC members were unable to be onsite due to a recent outbreak, their active involvement in the planning and promotion of these efforts demonstrates their ongoing commitment to being the voice of patients and families. Their engagement reinforces the importance of collaboration in creating a culture centered on empathy, respect, and quality care.

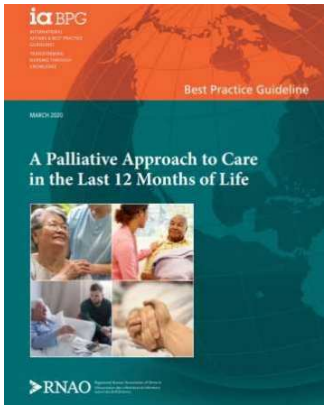
Best Practice Spotlight Organization (BPSO) Update

The Best Practice Guideline (BPG) focus for the upcoming cycle (April 2025–March 2026) will continue to be **"Palliative Care: A Person-Centered Approach to Care at the End of Life."** This focus builds upon and aligns closely with the work completed during the 2024–2025 cycle on the **End-of-Life Care** BPG.

This continued focus reflects the changing needs of the people we serve and supports our commitment to providing compassionate, respectful, and person-centered care at the end of life. Building on the work already completed, this next phase gives us the opportunity to strengthen our approach, maintain the progress we've made, and ensure that palliative care practices are consistently applied across all teams and services.

This guideline is especially relevant as we respond to the increasing complexity of our patient population, the growing need for high-quality, compassionate end-of-life care across all settings, and our continued commitment to ensuring equity and dignity in how care is delivered.

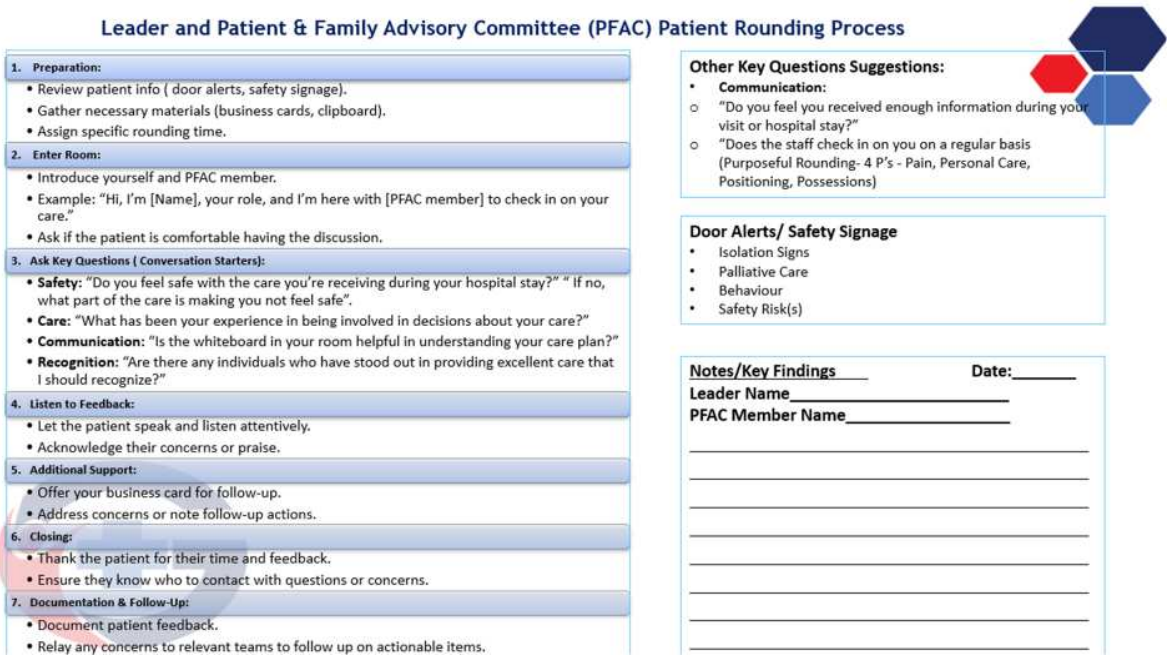
As the next steps, we will develop a detailed implementation roadmap for the Palliative Care Best Practice Guideline and continue engaging front-line staff, patients, and families to gather valuable input that will inform and shape our approach.



Patient Safety Plan Action- Leader and PFAC Patient Rounding

In celebration of Patient Experience Week, we introduced a new hospital-wide initiative focused on strengthening our connection with patients through regular leadership and PFAC rounding. To mark the launch, three senior leaders visited various units to speak directly with patients, hear their stories, and better understand their experiences of care. Six patients from Medicine, Rehab, and Emergency were engaged. Initial feedback highlighted opportunities to enhance communication using the patient whiteboard, improve patient engagement during specific times of day, and reduce environmental disruptions impacting rest and recovery. These insights will guide ongoing quality improvement efforts.

Communication to the team emphasizes that rounding is a tool for collaboration and feedback provided is not to assign blame. The aim of sharing feedback with the team is to foster open dialogue, shared accountability, and continuous improvement.



DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 7, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Accrediation 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 theme 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:
    - Both Global Workforce Survey and the Governing Body Assessment have been completed, with both exceeding the minimum response threshold that is required for HGMH to be qualified to contend for "Accredited with Exemplary Status".
        - The other requirements for this status are assessed as part of the survey and require that we meet 100% of the Required Organizational Practices (ROPs), as well as 95% of the "high priority" criteria and 95% of the "normal priority" criteria.
    - As of the date of this report, we stand at 89% complete for ROPs, 90% complete for "high priority" criteria, and 89% complete for "normal priority" criteria, though it should be noted that these are our own self-assessments of compliance. Ultimately it is the surveyors who will decide if we are compliant with the standards.
        - Regardless, these results show significant progress since the last report of February 2025, where we were at 70% compliance with ROPs and 74% compliant for high and normal priority criteria combined.

- Current efforts related to Accreditation continue to be focussed on updating policies and ensuring that evidence is documented for each item on the tracker and that the status of each criteria's compliance is noted accurately.
- For sites having their survey in the first few months of 2026, Accreditation Canada has waived the requirement to submit the "attestation" in July 2025 as they work out some issues with their online tools. They have also waived the "short notice" of the survey dates for the same group, through which they planned to advise facilities of their specific survey dates just 2-3 weeks in advance. As such, we now know that our surveyors will be arriving in Alexandria on February 8, with the survey taking place February 9-12, 2026.
- It is anticipated that we will receive the names and biographies of the surveyors assigned to our site within the next 5-6 months, and we have requested that at least one of them have experience with rural hospitals, so they will be familiar with the unique challenges we face.
- We should also be receiving the survey schedule in the next few months, and we will be scheduling meetings with different priority process groups, such as the Board of Directors, the Patient & Family Advisory Committee, and other specific internal committees and departments for surveyors to meet with the team and discuss how HGMH addresses the standards that apply to that group.

- Next steps with Accreditation are expected to be:
  - November/December: Submission of evidence to portal
  - November/December: Pre-survey logistics & planning
  - February 9-12, 2026: Onsite survey

CONSULTED WITH:

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

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

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: May 5, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Accreditation Standard Feature

Prepared by: Rachel Romany- Vice President Clinical Services, Quality, Chief Nurse 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 committee to discuss the standard and how HGMH achieves compliance, identifies opportunities for improvement, 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

Priority Normal **Priority Guidelines**: Quality Dimension Appropriateness

3.1.7 The governing body ensures that the organization uses client feedback to improve the quality of its services.
The governing body ensures that the organization collects feedback on client experience and satisfaction to use it for evaluation and improvement of its services. Client experience includes all the interactions a client and family have with the organization throughout the client journey, including the care provided and their interactions with service providers and as part of the care team. The governing body ensures that the organization seeks and encourages client and family feedback (that is diverse, and representative of the community served). Feedback is both positive and critical, about their experiences, to evaluate whether defined steps and processes occur at the right time and frequency. The organization also uses these data to set a baseline for future evaluations and identify strengths and opportunities for improvement. 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 collects and uses client satisfaction data to evaluate the effectiveness of the organization's communication with clients and families throughout the client journey. Understanding client experience and client satisfaction is an important component of making care more people-centred. The governing body ensures that the organization uses its findings to inform its quality improvement planning.

DISCUSSION QUESTIONS

- What does the hospital already do to meet this standard?-
    - Patient Satisfaction Survey results now include care ratings for gender diverse, sexual orientation, race and First Nations.
- What new things can the hospital implement to meet this standard?
    - Cultural Safety and Gender Sensitivity training for staff which is in our current QIP.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: January 30, 2025 Meeting Date Prepared for:

Subject: Annual Report Clinical & Organizational Ethics Committee (COEC) 2024

Prepared by: Chantal Mageau-Pinard / R. Romany

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

PURPOSE

The purpose of this briefing note is to provide a comprehensive, clear, and concise annual summary of the Clinical & Organizational Ethics Committee (COEC) meetings, aimed at ensuring transparency and keeping stakeholders informed on ethical matters impacting the organization. The note will outline key decisions and discussions from the meetings, highlight emerging issues and trends, and ensure the organization remains proactive in addressing ethical dilemmas while maintaining high standards of care. Additionally, it will foster ongoing ethical awareness, supporting the integration of ethical considerations into both daily practices and the broader organizational culture.

SITUATION & BACKGROUND

A brief description of the background to the issue.

The Ethics Committee helps guide and support decision-making, especially when it comes to complex situations like patient rights, treatment choices, and fairness in care. This collaborative approach ensures that the hospital maintains a high standard of care, while also respecting patients' rights and upholding ethical principles in all clinical practices.

The COEC did not receive any ethical dilemmas in 2024. However, the committee discussed strategies to enhance the visibility of its work to patients, staff, and other members of the organization, with the aim of providing guidance and support in situations where ethical dilemmas arise.

As part of the hospital's efforts to embrace the new continuous model for Accreditation and embed it into our daily work, the COEC featured a criterion from an accreditation standard that applies to this committee's work at each meeting. These features provide an opportunity for the committee to discuss the standard and how HGMH achieves compliance, identifies opportunities for improvement, while ensuring the committee is well-equipped to make informed decisions and recommendations related to quality

Different case studies were conducted during the year to offer a dynamic and interactive method for the committee and staff to refine their approach to decision-making, enhance their understanding of complex issues, and ensure the best outcomes for the patient:

- Substitute Decision Making (SDM), Power of Attorney (POA) and capacity
- End of life discussion
- Living at Risk

Case studies will continue to be presented to staff via lunch and learn 3-4 times a year hosted by our Ethicist.

The Clinical and Organizational Ethics Committee (COEC) is committed to supporting the ethical needs of the organization through education, consultation, and guidance on ethical matters. Our commitment to transparency, patient-centered care, and continuous improvement forms the foundation of our organizational success. The organization's mission, vision, and values ensure that ethics is not only a guiding principle but a fundamental aspect of decision-making throughout the organization.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: April 30, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Emergency Preparedness Update

Prepared by: J. Mattice - Manager of Projects, Emergency Preparedness, and Security

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

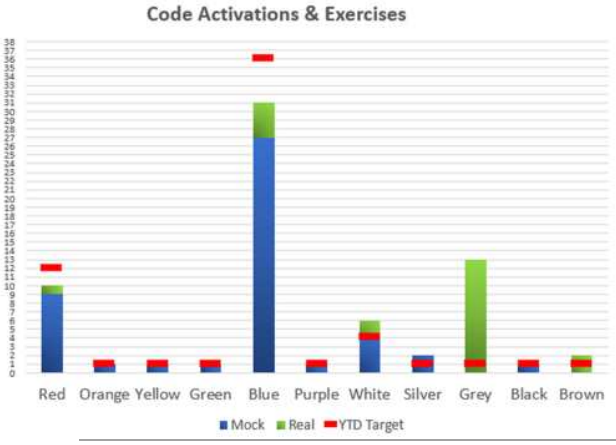
PURPOSE

- To provide an update on the hospital's emergency and disaster response work, presenting the final dashboard for the 2024 calendar year and the dashboard for 2025 to date

Final 2024 Dashboard

- All targets for 2024 were met except for known exceptions identified earlier in the year:
  - Mock Code Reds were below our targets, however, 10 code reds were performed throughout the year.
  - Mock Code Blue while this fell below the target of 36 mocks, the team did conduct a large number of mock code blues, and additional education was provided to nursing and physicians using simulations and training in Advance Cardiac Life Support (ACLS). All of which enhance the performance of actions during code blues.
- 13 actual Code Grey activations were recorded, representing a number of infrastructure failure types:
  - 9 Meditech downtimes
  - 1 minor electrical failure
  - 1 major electrical and phone failure
  - 1 boiler / HVAC failure
  - 1 network/computer failure (international Crowdstrike incident)
- 20 pending quality issues were rolled over to 2025's dashboard
- 2 policies not reviewed in 2024 were rolled over to the 2025 list of policies pending review

2024 Emergency Preparedness Dashboard – Final Results



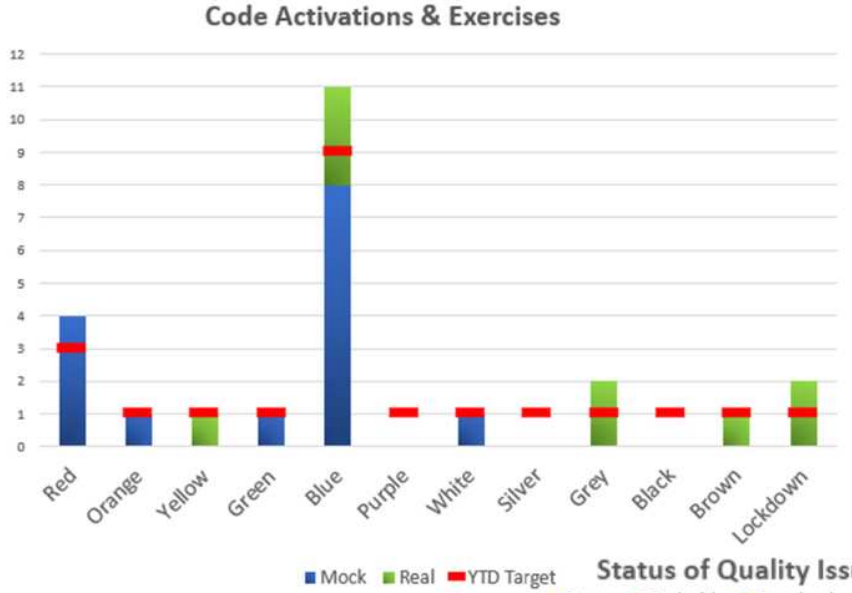
Quality Issues comprise action items identified in debriefings for real or mock code activations. These may be referred to other committees or departments and may be determined unfeasible to address.

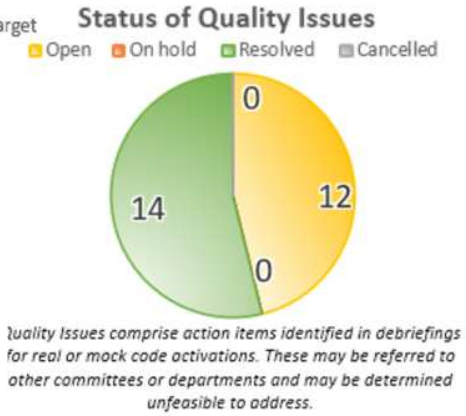
Red line above indicates percentage of the calendar year that has elapsed and is intended as a gauge to monitor policy progression.

2024 Dashboard *(as of April 30, 2025)*

- New code added to tracker: Code Lockdown with targeted exercise frequency of once annually
- Policy reviews are behind schedule, but updated workflows for each of the pending codes requiring redevelopment have been completed and shared with staff
- Flipcharts have been redesigned and reinstated throughout the facility
- At this time, there are no expected gaps for meeting activation targets for 2024
- Work is underway to establish the last major components of Emergency Preparedness Program pending development to comply with Accreditation Standard:
    - Continuity of Operations Plan (aka Business Continuity Plan)
    - Core competencies program
    - Crisis communications plan
    - Code Green
    - Other code response policy redevelopments (silver, purple, brown, grey, lockdown)

2025 Emergency Preparedness Dashboard – as of April 30, 2025





Quality Issues comprise action items identified in debriefings for real or mock code activations. These may be referred to other committees or departments and may be determined unfeasible to address.

Red line above indicates percentage of the calendar year that has elapsed and is intended as a gauge to monitor policy progression.

DECISION SUPPORT DOCUMENT FOR

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

Date Prepared: February 14, 2025 Meeting Date Prepared for: May 14, 2025

Subject: Guidelines for Managing Physician Professional Behaviour Policy

Prepared by: Dr. Lisa MacKinnon

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

PURPOSE

To provide an overview of the Guidelines for Managing Physician Professional Behavior Policy, which outlines the procedure for addressing complaints related to physician conduct.

IMPLICATIONS TO OTHER STANDING COMMITTEES

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

SITUATION & BACKGROUND

- This policy, initially known as the Resolving Medical Staff Conduct Complaints policy, has been revised and renamed to better reflect its purpose and scope.
- This policy represents an approach for physician professional behaviour and a framework for identification and management of unprofessional behaviour that is fair, focused, and progresses to resolution. Specifically, this policy's purpose is:
    - To establish respectful behavioural norms.
    - To establish a process by which the issue of unprofessional physician behaviour is managed.
    - To establish a commitment to fairness, respect, consensus and transparency.
- If a formal resolution of a complaint is needed, we follow a staged approach. The process begins with documenting the complaint on the Physician Complaint Process Formal Resolution Form, which is then sent to the physician named in the complaint and copied to the Chief of Department.
- The physician must provide a written response, which is submitted to both Medical Affairs and the Chief of Department.
- The Chief of Department will then connect with both the physician and the complainant, after which a written response is submitted to Medical Affairs for the physician's file, or escalated to the Chief of Staff if necessary.
- Once this process is completed, the RIMS is closed.
- The timeline for resolution depends on factors such as whether the physician needs to review the patient's file, and the time required to communicate with the complainant.

CONSULTED WITH:

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

- Medical Advisory Committee – October 8, 2024
- Senior Leadership Team - October 2024

IMPLEMENTATION & COMMUNICATION PLAN

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

- Professional Staff Association Meeting & Package – October 17, 2024

SUPPORTING DOCUMENTS/ATTACHMENTS

List any supporting documents or attachments

- Guidelines for Managing Physician Professional Behaviour Policy CLI.04.007.0.24

Physician Complaint Process
Formal Resolution

Date (date receive by Medical Affairs)		
Identification	**Details**	**Completed By**
Incident Type *(via RIMS, Info@hgmh, Verbal message)*		
Patient MRN# **or** (x) for Internal Complaint		
Attending Physician		
Chief of Department		
Details of Complaint		
Process	**Date Completed**	**Signed**
Notification and details of Incident report sent to Physician		
Response from Physician		
Notification and details of incident report sent to Chief of Department		
Response from Chief of Department		
Notification and details sent to Chief of Staff *(If Step Two or Three)*		
Responses sent to Chief of Staff *(if applicable)*		
Responses sent to MAC to review *(Step Three, Egregious Behaviour, Risk of Harm)*		
Responses sent to CHRO *(Step Three - If complaint is from employee or volunteer)*		
Conclusion to be Completed by: ☐ Step One ~ Chief of Department ☐ Step Two ~ Chief of Staff ☐ Step Three ~ MAC, and ☐ *(CHRO if applicable)*		
Incident File Closed *(to be completed by person who completes Conclusion)*		
Complaint, Responses, and Conclusion sent to physician and copy on file in Medical Affairs.		

Document Name:	Guidelines for Managing Physician Professional Behaviour	
Document Number:	CLI.04.007.0.24	
Review Period:	☒3 years ☐1 year	**Manual:** N/A
Classification: Clinical	**Section:** Medical Staff	
Owner: Chief of Staff	**Signing Authority:** Medical Advisory Committee	

POLICY STATEMENT:

Hôpital Glengarry Memorial Hospital (HGMH) is committed to fostering a professional, healthy and safe work environment for all team members including staff, volunteers and physicians. It is the expectation of the Hospital that staff, physicians and volunteers demonstrate professional behaviour that is aligned with HGMHs Values in their interactions.

HGMH is committed to promoting a work environment that is professional, mutually respectful and free from harassment. Any physician, employee, or volunteer can communicate issues/concerns that are related to employment, the work environment and/or Hospital policies and procedures, without fear of reprisal. HGMH supports these individuals in communicating an individual concern.

HGMH is compliant with regulatory requirements and will report a physician to the College of Physicians and Surgeons (CPSO) when there is reasonable grounds to believe that a regulated health professional practicing in the facility is incompetent, incapacitated or has sexually abused a patient.

This policy represents an approach for physician professional behaviour and a framework for identification and management of unprofessional behaviour that is fair, focused, and progresses to resolution. Specifically, this policy's purpose is:

- To establish respectful behavioural norms.
- To establish a process by which the issue of unprofessional physician behaviour is managed.
- To establish a commitment to fairness, respect, consensus and transparency.

GUIDELINE:

Where there is a conflict between two parties, the individual should discuss the complaint/concern with the person with whom the issue is with, in an attempt to resolve the issue.

In the event the individual cannot resolve the complaint/concern with the person with whom the issue is with, or if the individual is not comfortable in discussing the issue, the individual should discuss the issue with their manager or immediate supervisor. It is recommended that this discussion occur in a timely manner. At this meeting, the approach for resolution can be determined. There are two approaches available for

resolution: informal and formal.

Informal Resolution Approach

If the concern/conflict involves a physician; the Department Chief will co-ordinate a meeting with the physician, the individual with the concern, and if applicable the Clinical Manager. If a formal complaint is made by an employee or volunteer, the Chief Human Resources Officer will be involved in the investigatory process and will be the main contact person for the complainant.

An informal dialogue will occur outlining concerns and establish a goal towards resolution.

Formal Resolution Approach

A staged approach to the investigation and resolution to a complaint should be followed. This means a progressive approach to managing unprofessional behaviour with the intention of remediation.

Remedial support with respect to modifying behaviours through providing linkages to professional resources or assisting to develop a health plan should be emphasized and offered.

Stage One interventions

These are warranted where behaviour occurs for the first time and is perceived as being low in severity. The Department Chief should keep a record of the type of behaviour and document the resolution.

Examples of the types of behaviours which might typically require a Stage One intervention are:

a) inappropriate language;
b) threats;
c) angry outbursts (i.e. yelling);

Stage Two intervention

This is required for behaviour that is of moderate severity or when Stage One behaviour has been repeated despite intervention.

Examples of the types of behaviour which might generate a Stage Two intervention are:

a) inappropriate or unprofessional behaviours that have generated several written complaints from patients, staff, other physicians, students, administration etc.; (refer to Appendix A)
b) breaking or throwing things;
c) a persistent pattern of Stage One behaviour;

Refer to Procedure section regarding guidelines for documentation.

Stage Three intervention

This is required for behaviour that has continued past Stage Two despite appropriate interventions and where one sees a persistent pattern of behaviour with increasing severity or a behaviour of such an egregious nature that there is concern about self harm or harm to others.

Crisis Intervention

This may be required in the event of the sudden appearance of behaviour too egregious for a staged response. In situations of a crisis intervention, the physician will be informed that this action is not definitive and that the incident and its repercussions will be revisited when the distress of the moment has passed.

Examples where crisis intervention is required might include:

a) Threats to physically harm him/herself or others.
b) There appears to be an unacceptable legal liability arising from the physician's behaviour.
c) Immediate patient care is negatively affected by the physician or there is a significant potential that it could be.

At any stage, documentation regarding unprofessional behaviour and activities undertaken pursuant to the reports, either firsthand oral or written, will be retained in the physician's file in the Medical Affairs office.

Failure to maintain an acceptable standard of behaviour during the remediation period may have automatic repercussions such as presentation and discussion at the MAC, mid-term action, suspension of privileges, and a concomitant report to the College of Physicians & Surgeons of Ontario (CPSO).

All physicians who are being recruited to the organization will be apprised of the Hospital's expectation with respect to behaviours.

PROCEDURE:

Each stage of the Resolution Approach should be documented using the Physician Complaint Process Formal Resolution form (431-004-XX) and follow due process. The file will document:

a) all discussions that have occurred.
b) evidence that the physician has been given notice that his/her behaviours have been perceived to be unacceptable.
c) evidence that there has been an attempt to understand whether any mitigating factors were present at the time of the unprofessional behaviour that may have contributed to or caused the behaviour.
d) specific evidence of any resources offered, or interventions offered / or mandated to assist the physician in changing behaviours.

e) evidence of any commitments made by the physician outlining his/her intention to adjust behaviour.
f) if interventions/resources have been provided to the physician, reports from the provider should be on file.
g) evidence that regular feedback has been provided to the physician.
h) evidence that the consequences of continuation of unprofessional behaviour have been openly and clearly outlined to the physician.

If a formal complaint is made by an employee or volunteer, the Chief Human Resources Officer will be involved in the investigatory process and will be the main contact person for the complainant.

Stage One Intervention:
The Chief of Department will meet with the physician and:
a) describe the incident to the physician and explain why the observed behaviour is considered to be unprofessional.
b) provide the physician with an opportunity to respond.
c) assist the physician in understanding how others have interpreted the behaviour.
d) provide supportive counselling, if needed, the physician may be referred to external resources for assistance.
e) in collaboration with the physician decide as to the format and substance of a response to the reporter in order to bring resolution to the complaint.
f) document the discussion and intended follow-up which will be maintained in the physician's file.
g) follow-up, as agreed upon, and provide feedback to the physician on a regular basis.
h) complete a summary of the situation and actions taken document in the physician's file

Stage Two Intervention
The Chief of Department will:
a) Notify the Chief of Staff.

The Chief of staff, in collaboration with the Chief of the Department will meet with the physician and:
a) describe the incident to the physician and explain why the observed behaviour is considered to be unacceptable.
b) provide the physician with an opportunity to respond.
c) assist the physician in understanding how others have interpreted the behaviour.
d) provide supportive counselling; if needed, the physician may be referred to external resources for assistance.
e) in collaboration with the physician decide as to the format and substance of a response and
f) develop an action plan between the physician and hospital. This action plan will address the following elements:

i) method of redress (personal counseling, psychological testing, leadership training, substance abuse therapy, a reading course, written project, tutorial sessions, etc.).
ii) method of monitoring for change/progress.
iii) name of mentor during the process who is satisfactory to both the physician and the hospital.
iv) method for the determination of satisfactory progress (behaviour benchmarks).
v) timeframe within which progress must be demonstrable.
vi) consequences if no progress is observed or if non-compliance with the methods and terms of remediation is noted.

g) The documentation of the above will be kept in the physicians file in the office of the Medical Affairs office.
h) notify the physician, in writing, that a third incident may result in review of behaviour by the Medical Advisory Committee and that the question of continuation of privileges will be discussed at that time.
i) Consider referring the physician to an external resource.
j) Document the incident in CMARS.

Stage Three Intervention

The Chief of Department will:

a) Inform the Chief of Staff

The Chief of Staff, in collaboration with the Chief of the Department will meet with the physician and:

a) describe the incident to the physician and explain why the observed behaviour is considered to be unacceptable.
b) provide the physician with an opportunity to respond.
c) assist the physician in understanding how others have interpreted the behaviour.
d) provide supportive counselling; if needed, the physician may be referred to external resources for assistance.
e) develop an action plan between the physician and hospital. This action plan will address the following elements:
i) method of redress (personal counselling, psychological testing, leadership training, substance abuse therapy, a reading course, written project, tutorial sessions, etc.)
ii) method of monitoring for change/progress.
iii) name of mentor during the process who is satisfactory to both the physician and the hospital.
iv) method for the determination of satisfactory progress (behaviour benchmarks)
v) timeframe within which progress must be demonstrable

vi) consequences if no progress is observed or if non-compliance with the methods and terms of remediation is noted.

f) concerns to be brought forward to the Medical Advisory Committee in-Camera.

The President & CEO, and VP Clinical Services, Quality and CNE will be notified if the behaviour in question is of a sexual nature, significant Patient Risk, or if potential expectation for medical /legal claim or involves concern of criminality or police.

DEFINITIONS:

Unprofessional Behaviour: Unprofessional physician behaviour occurs when the use of inappropriate words, actions or inactions by a physician interferes with his or her ability to function well with others; and thereby leading to an unacceptable work environment, or the behaviour interferes with, or is likely to interfere with, quality health care delivery.

Advocacy versus Unprofessionalism: Physicians, individually and collectively, have a responsibility to advocate for their patients. On occasion, in the course of such advocacy, physicians may find themselves in conflict with colleagues or with the staff or the administration of the institution in which they work. In such cases, it may be difficult to evaluate whether the behaviour is disruptive as defined by the CPSO. Each physician should carefully assess the impact of his/her conduct on the ability to deliver quality health care to the patient or patients. When the delivery of healthcare is impaired by the advocacy efforts, the physician should evaluate whether the advocacy effort is, in fact, in the patient's best interests.

Egregious Behaviour: can be a single act that poses an immediate threat to patient care or the safety of others. Disruptive behaviour may, in rare circumstances, be demonstrated in a single egregious act but is more often composed of a pattern of behaviour. The gravity of disruptive behaviour depends on the nature of the behaviour, the context in which it arises, and the consequences flowing from it.
Some examples include:

- the physician is so distressed or out of control that he or she poses a safety risk to other workers in the environment;
- the physician threatens to physically harm him or herself or others;
- the behaviour appears to create unacceptable legal liability; and
- the behaviour poses an immediate threat to patient care.

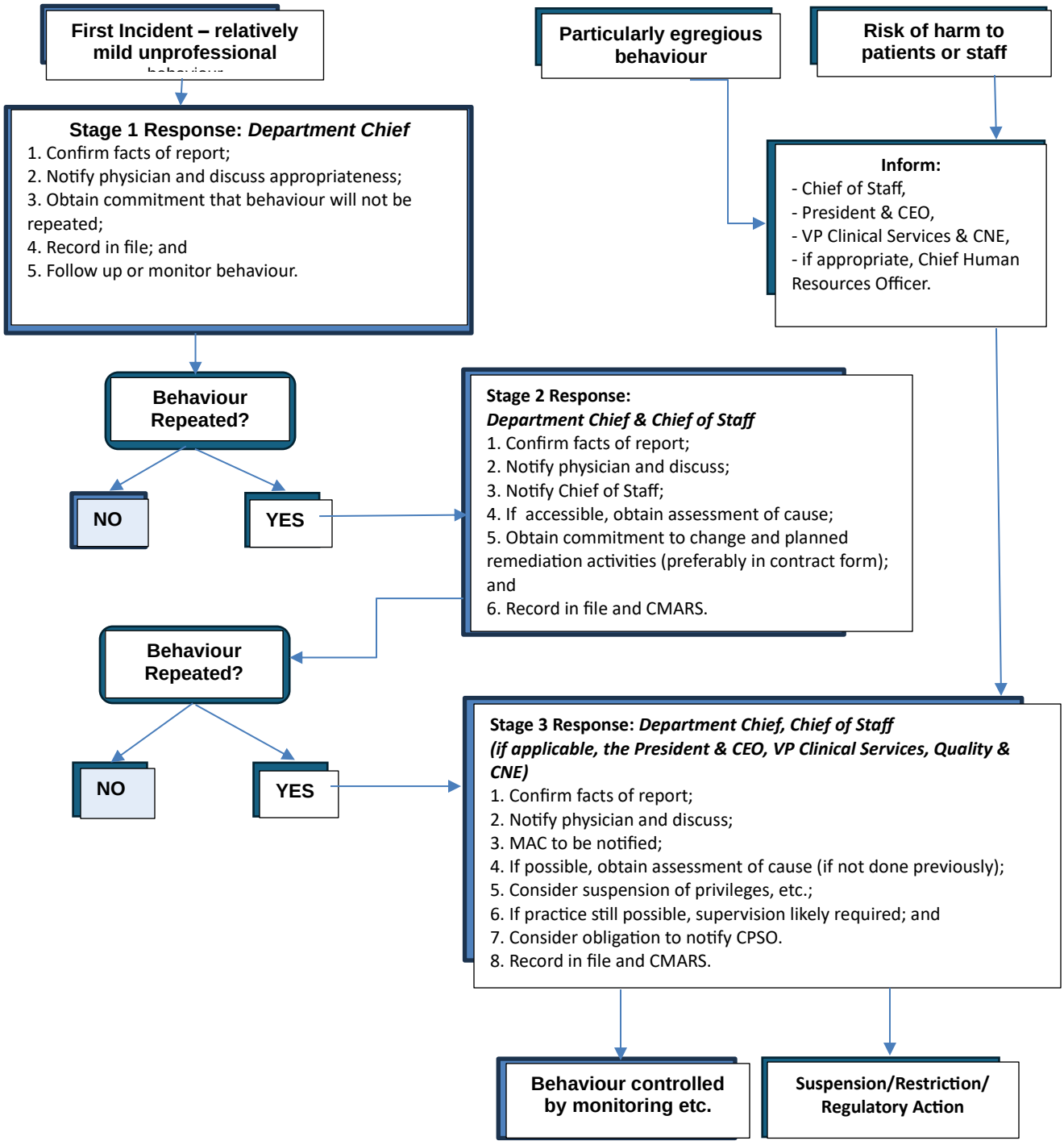
ASSOCIATED FORMS:

Form Number	Form Name
431-004-XX	Physician Complaint Process – Formal Resolution

REFERENCES:

1. Guidebook for Managing Disruptive Physician Behaviour, College of Physicians and Surgeons of Ontario and the Ontario Hospital Association, April 2008.
2. Physician Behaviour in the Professional Environment. College of Physicians and Surgeons of Ontario, approved November 2007, published February 2008
3. Regulated Health Professions Act (RHPA) s.1 (3)
4. Physician Health Program at the Ontario Medical Association
5. North York General Hospital Guideline for Physician Professional Behaviour

APPENDIX A – Guidelines for Managing Physician Professional Behaviour



Appendix B: Sample Reply to Patient or Family Submitting a Written Formal Complaint

Thank you for bringing your recent experience to our attention. We have received your complaint, and we want to assure you that we take all patient concerns very seriously.

Your feedback is invaluable to us as it helps us to improve our services and ensure the highest quality of care for all our patients. We are currently reviewing your case in detail and will conduct a thorough investigation to address the issues you have raised.

We understand the importance of your concerns and are committed to resolving this matter promptly. A member of our team will be in touch with you within the next few days to further discuss your experience. If you have any additional information or questions in the meantime, please do not hesitate to contact us by emailing info@hgmh.on.ca or calling 613-525-2222 X4335.

Sincerely,

Appendix C: Sample Reply to Patient or Family Commenting About the Hospital on Social Media

We value input from our patients and their families as it helps us improve the quality of care and services we provide. We invite you to contact our Patient Relations team at 613-525-2222 X4335 or info@hgmh.on.ca so we can discuss your concerns in greater detail. We appreciate the opportunity to address any issues you may have encountered and look forward to hearing from you soon.