Perth and Smiths Falls District Hospital
Board Quality Committee
Thursday, December 9th, 2021
Via Zoom
7:30 a.m. – 9:00 a.m.

Present:	L. Drynan (Chair), D. Thomson, K. Clupp, S. Bird, H. Mostamandi, G. Church, M. Cohen, K. Kehoe and C. Dolgowicz
Guests:	K. Wickens, J. Hewitt, M. McLeod-Frazer, J. Hall and D. Hodgins
Regrets:	N. Shaw, Dr. A. Kuchinad, Dr. W. Hollis and A. Thomlinson
In Attendance:	C. Rustan, Recording Secretary

1. Call to Order – L. Drynan

L. Drynan, Chair, called the meeting to order at 7:34 a.m.

2. Adoption of Agenda – L. Drynan

Deferred

3. Approval of Minutes – L. Drynan

Deferred

4. Closed Session Items

Deferred

5. Education Presentation – Accreditation

The accreditation cycle is approximately every 3-5 years depending on the jurisdiction and the type of care that is provided. Accreditation Canada has recently changed where they will be completing Accreditation every year.

The Accreditation Canada seal ensures that the health care organization meets the standards and delivers quality care. Accreditation is only awarded after the organization submits successful documentation that is in compliance with the current standards. Compliance is determined by evaluating written documents, policies, procedures and it also includes an onsite inspection that is done by the surveyors. The onsite inspections will be carried out by a team of inspectors, who are qualified by training and experience.

H. Mostamandi explained that the Accreditation teams go through several questions to ensure that we are ready for Accreditation and to address any gaps within the program. H. Mostamandi explained that the Strategic Plan will determine how streamlined the Accreditation process will be for our staff who are clinical and non-clinical.

Accreditation is all about improving safety and providing a greater quality of care. If a policy and procedure is not in place then it must be established to support the accreditation status survey goals.
H. Mostamandi explained that PSFDH could have clear policies/procedures; however, they are irrelevant if staff are not utilizing them or if staff are not familiar with the process to access them.

H. Mostamandi meets on a monthly basis with Accreditation Canada to ensure that we are proceeding in the right direction. All of Accreditation Canada standards are developed through a rigorous process and they consist of two sections which are a criteria and a guideline.

H. Mostamandi explained that a high priority criterion is related to safety, ethics, risk management and quality improvement. A required Organizational Practice is an essential practice that an organization must have in place to enhance client safety and minimize risk. It is crucial that we meet all of the ROPs in order to get exemplary standing. ROPs are quite detailed to make sure that there is no room for error.

H. Mostamandi went through and explained the different areas that fall under the ROPs.
H. Mostamandi discussed Safety Culture, Communication, Medication Use, Worklife/Workforce, Infection Control and Risk Assessment. There are a significant amount of items that fall under each of these categories.
H. Mostamandi provided an example for all of the items under each category.

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A stop sign identifies an ROP and this is due to the fact that it makes us stop and ensure that we are complaint. All those tests have to be met in order to pass and if we fail an ROP then we are no longer qualified to receive an exemplary status.

Discussion ensued regarding the possibility of pushing back Accreditation given the certain situation with COVID-19. M. Cohen informed the committee that Accreditation can only be pushed back for a certain amount of time and it can not exceed past 18 months from the initial appointed date, which PSFDH is currently at. M. Cohen did add that a request was made to have the May date pushed back and it was declined.

K. Clupp questioned whether the province mandates hospitals to participate in Accreditation or is this discretionary on our part? M. Cohen advised that Accreditation is a voluntary process for health institutions. However, there are negative impacts if organizations do not participate, such as not being able to support students/trainees of any kind if the organization doesn't hold an accreditation status. This is a critical piece as PSFDH tends to recruit those students who are in the building.

J. Hewitt inquired about what interface you would like to see from the Governance committee in terms of standards set by Accreditation, should they be board functioning? M. Cohen stated that there are Governance standards and the biggest piece at the moment is the Governance survey that was sent out previously by K. Kelly. We are currently collecting data from the surveys, so there will be more information to follow on what is to be expected.

It was suggested that prepping sessions be provided again closer to the Accreditation date. The prepping sessions should include the chair and CEO to provide some speaking notes and some mock tests prior to Accreditation. This is to ensure that everyone is on the same page with their answers. G. Church suggested reviewing where the gaps were last time and encouraged the committee to work on building confidence in those areas. K. Clupp felt it would be beneficial to work on the areas that require improvement vs. the speaking notes.

L. Drynan, M. Cohen, H. Mostamandi and J. Hewitt will start to organize prepping sessions in the new Year. Prepping sessions will be added to the Governance Committee Agenda in January.

H. Mostamandi informed the committee that teams have been established which are also known as working groups. The working groups have team leads and they are responsible for going through the standards and their departmental policies and procedures to ensure everything is up to date. The working groups fill in the action plan template and the purpose of this action plan is to identify and how we are doing. To date PSFDH does not have any new processes that need to be implemented, but we focus on improving some of them.

6. Business Arising from Minutes

6.1 Board Quality Committee Workplan – 2021-2022

Deferred

7. Standing Items – N. Shaw

7.1 Strategic Operational Plan – N. Shaw

Deferred

7.2 Performance Metrics

i. Balanced Scorecard

Deferred

ii. Patient Satisfaction Surveys – NRC & OBS

Deferred

iii. Incident Reports

- **Medication Incidents**

  Deferred

- **Patients Falls**

  Deferred

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7.3 Patient and Family Advisory Council (PFAC) Update – D. Thomson
Deferred

8. New Business
8.1 HR Union Matters (Corporate Scorecard)
Deferred

9. Other Business
9.1 COVID-19 Update
Deferred

9.2 NRC Update
Deferred

10. Next Meeting date:
The next Board Quality meeting is scheduled for Thursday, February 10th, 2022 at 7:30am via Zoom.

11. Adjournment - L. Drynan
MOVED by C. Dolgowicz
SECONDED by G. Church

THAT the December 9th, 2021 Board Quality Committee meeting adjourned at 8:15a.m.
CARRIED.

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