Perth and Smiths Falls District Hospital
Board Quality – Minutes (Closed)
Thursday, January 8, 2026
Perth Boardroom and via Teams
7:30 a.m. – 9:00 a.m.

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1. Call to Order – I. Boyle

MOVED in closed session by consensus

THAT the PSFDH Board Quality Committee Meeting move into a closed session at 8:10am. CARRIED.

2. Approval of Agenda

MOVED by consensus

THAT the January 8, 2026 Board Quality Committee Closed Agenda were approved as circulated.

All in Favour
CARRIED.

3. Declaration of Conflict of Interest

No conflicts were declared.

4. Approval of Minutes

MOVED by consensus

THAT the November 13, 2025 Board Quality Committee Closed Agenda were approved as circulated.

All in Favour
CARRIED.

5. Business Arising from the Minutes

Nil

6. New Business

6.1 QRCA – 2025-2

Overview:

- 35-year-old male
- Comorbidities: Type 2 diabetes, obesity, hyperlipidemia.
- Care pathway: Presented to Perth ED, admitted to Med Surg Perth, then ICU, and later transferred to Kingston for higher-level care

History:

- Presented with two hours of upper abdominal pain and chest discomfort
- Triage at 11:25, first physician assessment at 12:19
- Initial blood work was lipemic, unable to be processed on-site; samples required transport to Kingston
- Pain escalated despite early interventions; additional diagnostics ordered, including CT imaging, requiring transfer to Smiths Falls and return to Perth
- Diagnosed with acute pancreatitis and admitted to Med Surg Perth
- Monitoring overnight included IV fluids and pain control; continued elevated respiratory rate and persistent pain
- Next-day labs revealed severe hyperglycemia (glucose 28.3), prompting concern for diabetic ketoacidosis (DKA)

Incident Summary:

- DKA protocol initiated; patient transferred to ICU
- In ICU, IV insulin was started; Narcan administered to rule out opioid-related sedation
- A code blue occurred several hours later; patient was resuscitated and transferred to Kingston for higher-level care
- A debrief did occur immediately after the code, although not all involved staff were able to attend
- Key concerns identified by nursing and internal medicine:
  - Inability to process any blood work locally due to lipemic samples, causing reliance on Kingston turnaround times
  - Internal medicine consultation initiated later than optimal
  - Earlier ICU consideration may have been warranted
  - Overnight blood work planning left to MRP, but would still require off-site processing
  - Staff expressed distress due to caring for a deteriorating patient without actionable lab results
  - External partners advised continuing management with fluids and analgesia despite site limitations.
- Patient ultimately passed away; rare etiology noted by internal medicine specialists

Recommendations:

Clinical Processes & Assessment

- Reassess workflow for post-CT evaluation, ensuring patients are reviewed prior to unit transfer when clinically indicated
- Earlier involvement of internal medicine and earlier ICU consultation should be considered in similar cases

Laboratory Processes

- Conduct a review of lab capabilities, especially regarding handling lipemic samples.
- Improve communication standards for urgent labs, including:
  - Clear distinction between true STAT orders vs. default EMR STAT orders
  - Requirement for direct phone communication between units and lab for urgent specimens
- Reassess workflow with PSFDH & Kingston lab transportation, especially after hours

Communication & Handover

- Strengthen documentation and re-assessment processes during inter-department transfers.
- Ensure all staff are included in immediate post-code debriefs whenever possible.

Education & System Review

- Reinstate Morbidity & Mortality (M&M) rounds and use this case as an example for system-level learning.
- Continue integrated QRCA processes involving interdisciplinary teams while ensuring space for physician-specific clinical review

Questions and comments from the BQ members:

- If we had BW, would that have changed the course of this case?
  - It may have made a bit of difference – hindsight. It was a very rare case for this patient
  - Number of factors in dealing with pancreatitis – fulminant pancreatitis. Given his hyperlipidemia, it may not have made a difference but there are different factors of the patient's care that need to address

- External partners – elaborate who they were and what was the basis of resistance?
  - Critical (a 1-800 #) is called regarding a patient requiring transfer from the current facility. This process is typically reserved for life-or limb-threatening situations or other urgent circumstances. The receiving service then begins searching for an available ICU bed
    - Once an ICU bed is located, an internal medicine physician or ICU physician engages in a case review. The case is presented, and a request for patient transfer is made. The receiving physician must agree to accept the case before any transfer can occur- physician to physician call
    - A patient cannot be placed in an ambulance and sent to a tertiary center without confirmed acceptance. If acceptance is not granted, continued care must be provided at the originating facility to the fullest capability available
- How many times does critical refuse or delay a transfer
  - Critical doesn't refuse – they are a conduit which they connect the doctors accepting hospitals
- Does sharing the EMR help with communicating to other hospitals?
  - Brockville, Belleville, Napanee and Kingston - all operate on the same EMR platform, while Ottawa uses a different system. Documentation charts only reflect observed information. The narrative created in the chart is then interpreted by the reader and incomplete or unclear documentation may lead to incorrect or limited conclusions.
  - These cases are reviewed in M&M rounds because an educational component exists. The review identifies situations where different actions may have been possible, prompting further discussion to support learning and quality improvement.

6.2 QRCA – 2025-4

Overview:

- 34-year-old female, pregnant eight times and seven successful births (G8, P7)

History:

- Confirmed a miscarriage at 10 weeks gestation presenting with vaginal bleed
- Presented to the ED twice; first encounter there were no concerns

Incident Summary:

- December 9th the patient returned to the ER and experienced a syncopal episode
- Found to be in hemorrhagic shock, requiring an emergency blood transfusion
- Patient and spouse reported that transfusion risks were not discussed
  - Consent form could not be located - though the emergency physician reported that consent had been completed
- Patient developed alloimmunization, requiring increased monitoring for future pregnancies
  - Alloimmunization complicates future transfusions because patients need specially matched blood, which can delay care and raise clinical risk

Recommendations:

- Documentation, Consent & Patient Education
  - During the review of the patient consent form, no information regarding the risk of alloimmunization was included, and this has now been identified for addition
  - The updated informed consent document has completed the policy review committee process and is ready for implementation
  - The patient information sheet has been finalized using content from ORBCoN (Ontario Regional Blood Coordinating Network), with organizational headers added and a disclaimer indicating that the material is for educational purposes
  - The informed consent policy is currently in final stages of revision
  - Once the complete package is finalized, the information will be shared with providers through MQA to ensure clear communication of all updates
- Training & Clinical Practice
  - Resume Morbidity & Mortality (M&M) rounds; consider using this case as a teaching scenario
  - Review staff training related to pregnancy-specific concerns (e.g., 1 in 13 risk of alloimmunization in women)
  - Review Bridge Program training processes for relevant staff
  - Consider establishing a transfusion officer role for oversight of training for physicians and nurses
- Process & System Improvements
  - Review Monoferric supply availability in the ED
  - Review transfusion workflows between ED and OR within Cerner

Questions and comments from the BQ members:

- Is it possible to have an electronic signature vs. paper and is the consent form electronically uploaded and printed directly from the EMR, or is an additional paper copy required to be stored separately?
  - One issue identified during the previous review was the lack of clarity regarding the scanning workflow and the appropriate destination for scanned documents. The process has since been clarified. Scanning is now available 24/7 with Patient Registration, allowing all documents to be scanned immediately
  - At present, consent forms are not incorporated into Cerner at most hospitals
  - The consent form continues to be a paper-based document for now
- What was the outcome in this case for the patient?
  - The patient developed antibodies and will require additional monitoring and care for future pregnancies
  - The clinical team delivered appropriate lifesaving treatment
- Would the fact that this event occurred three days into the go-live period have changed the outcome?
  - Improved understanding of scanning and documentation workflows would likely have strengthened the record of informed consent
  - It is likely that earlier familiarity with the new system would have prevented the loss of the consent form, as increased comfort with the workflow and prompts within Bridge would have supported more reliable capture of consent-related documentation

6.3 QRCA Summary 24-25 and 25-26:

B. Smith presented the Summary QRCA

Fiscal Year 2024–25

- 14 QRCAs completed
- 73 recommendations generated
- 57 recommendations completed to date
- 7 recommendations in progress
- 9 recommendations omitted (e.g., lack of funding for ED flow navigator or geriatric emergency nurse)
- Communication with Ontario Health at Home and resource nurse roles identified as ongoing issues

Fiscal Year 2025–26

- 5 QRCAs completed; 1 pending
- 26 recommendations generated
- 5 completed; 19 in progress; 2 omitted
- Decrease in QRCAs due to improved reporting pathways and appropriate use of morbidity and mortality (M&M) rounds

Recommendations in Progress:

- Enhancing weekend imaging capabilities, particularly availability of CTA with contrast; funding opportunities are being explored to expand CT hours
- Incorporation of feedback from M&M rounds
- Review of transfusion-related patient education materials for in-hospital use and discharge
- Evaluation and improvement of documentation practices related to discharge decision-making

Completed Items:

- Expansion of non-violent crisis intervention training to include physicians and addition of an educator to increase course availability
- Review and modernization of workplace violence policies and procedures
- Completion of the blood consent review to ensure alignment with Ontario Regional Blood Coordinating Network (ORBCoN) standards.

Omitted Items:

- A recommendation related to delays in transfer by emergency medical services was omitted. As of February 2025, the province implemented a new Medical Priority Dispatch System, representing a provincial overhaul outside the organization's scope of control.

Next Steps:

- The team will continue advancing the initiatives currently in progress and maintain focus on recommendations from 2024/2025
- Work continues on the next QRCA
- Integration of M&M rounds into the Quality Framework will proceed alongside QRCA activity

7. Adjournment – I. Boyle

Moved out of Closed Session by Consensus

THAT the PSFDH Board Quality Committee moved out of closed session at 8:50am.
CARRIED.