

AGENDA

Committee:	Medical Advisory Committee				
Date:	November 9 th , 2023		Time:	8:30am-9:30am	
Location:	Boardroom B110 / WebEx				
Chair:	Dr. Sean Ryan		Recorder:	Alana Ross	
Members:	All SHH Active / Associate, CEO, VPs, Clinical Managers				
Guests: <i>(Open Session Only)</i>	Heather Zrini, Shari Sherwood, Joanna Smorhay				
	Agenda Item	Presenter	Anticipated Actions	Time Allotted	Related Attachments
1	Call to Order / Welcome				
2	Guest Discussion				
2.1	ACT-FAST Tool	Smorhay	Presentation Discussion	20min	<ul style="list-style-type: none">• ACT-FAST Tool• ACT-FAST Implementation HHS• 2017-02-ACT-FAST-Drip & Ship Process Map SGH & AMGH• 2017-02-ACT-FAST-Protocol-AMGH TIA Process• 2023-04-ACT-FAST-Protocol-HPED to ED Emergency Stroke Transfers for Walk-In Stroke
3	Approvals and Updates				
3.1	Previous Minutes	Ryan	Decision	1min	<ul style="list-style-type: none">• 2023-10-12-MAC Minutes
	<i>*Draft Motion: To accept the October 12th, 2023 MAC Minutes.</i>				
4	Business Arising from Minutes				
4.1	CT Scanner	Trovato	Update	1min	
4.2	P4R Funding	Chair / COO	Discussion Decision	15min	
4.3	Urgent Palliative Follow-Up Clinic	Kelly	Information / Discussion	5min	<ul style="list-style-type: none">• Urgent Palliative Follow-Up Clinic
4.4	Physician Committee Assignments & Dates	Chair	Update	1min	<ul style="list-style-type: none">• 2023-11-02-Chairs and Dates of Committee Assignments for MAC
4.5	Staff WiFi	Sherwood	Update	1min	
5	Medical Staff Reports				
5.1	Chart Audit Review	Nelham / McLean	Information	15min	<ul style="list-style-type: none">• C Diff attachment for ROP
5.2	Death Audit Review	Patel	Information	2min	
5.3	Infection Control	Kelly	Information	5min	
5.4	Antimicrobial Stewardship	Nelham	Information	5min	
5.5	Pharmacy & Therapeutics	Patel	Information	5min	
5.6	Lab Liaison	Bueno	Information	5min	

5.7	Community Engagement Committee	Ondrejicka	Information	5min	
5.8	Recruitment and Retention	Ryan	Information	5min	
5.9	Quality Assurance Committee	Nelham / Wick	Information	5min	<ul style="list-style-type: none"> • 2023-11-QIP Dashboard
<i>*Draft Motion: To accept the November 9th, 2023 Medical Staff Reports to the MAC.</i>					
6	Other Reports				
6.1	Lead Hospitalist	Patel	Information	5min	
6.2	Emergency	Nelham	Information / Discussion	10min	
6.3	Chief of Staff <ul style="list-style-type: none"> • Exeter Villa Physician Coverage 	Ryan	Information / Discussion	10min	<ul style="list-style-type: none"> • 2023-11-Report to Board-CofS
6.4	President & CEO	Trieu	Information	5min	<ul style="list-style-type: none"> • 2023-11-Report to Board-CEO
6.5	CNE	Wick	Information	5min	<ul style="list-style-type: none"> • 2023-10-30-Media Release re OBSP Expansion • 2023-11-EMS Destination Protocol (protocol list only) • 2023-09-SHH Sep Incident Report
6.6	COO	Trovato	Information	5min	<ul style="list-style-type: none"> • 2023-11-Report to Board-CEO (PENDING)
6.7	Patient Relations	Klopp	Information	5min	<ul style="list-style-type: none"> • 2023-11-Report to Board-Patient Relations
<i>*Draft Motion: To accept the November 9th, 2023 Other Reports to the MAC.</i>					
7	New and Other Business				
8	Education / FYI				
8.1	Sessions Available	Walker	Information	1min	
9	Next Meeting & Adjournment				
	Date	Time		Location	
	December 14 th , 2023	8:30am-9:30am		Boardroom B110 / WebEx	

TRIAGE TOOLS FOR ACUTE STROKE < 24 HOURS

FAST Stroke Screen:

FACE

- ☐ Drooping?
- ☐ Normal?

OR

ARMS

- ☐ Weakness?
- ☐ Normal?

OR

SPEECH

- ☐ Slurred?
- ☐ Normal?

AND

TIME

- ☐ Less than 24 hours?

- ✓ One or more symptoms from Face, Arm, Speech AND
- ✓ LAST SEEN NORMAL less than 24 hours



IF ≤ 6 hours, activate Acute Stroke Protocol

IF 6 - 24 hours, Complete **ACT-FAST**

ACT FAST Stroke Screen:

STEP 1



Proceed if positive



“ARM” (one-sided arm weakness)

Position both arms at 45° from horizontal with elbows straight

POSITIVE TEST: One arm falls completely within 10 seconds

For patients who are uncooperative or cannot follow commands:

POSITIVE TEST: Witness minimal or no movements in one arm and movements in other arm

STEP 2



Proceed if positive



If RIGHT ARM is weak

“CHAT” (Severe language deficit)

POSITIVE TEST: Mute, speaking incomprehensibly or unable to follow simple commands

If LEFT ARM is weak

“TAP” (eye gaze & shoulder tap)

Stand on patient’s weak side

POSITIVE TEST: Consistent gaze away from weak side

POSITIVE TEST: Does not quickly turn head/eyes to you when shoulder tapped and first name called

STEP 3



If positive
activate
Acute Stroke
Protocol

Physician will assess EVT Eligibility

1. Deficits are NOT pre-existing (mild deficits now worse are acceptable as true deficits)
2. Living at home independently – must be independent with hygiene, personal care, walking
3. Does NOT have stroke mimics: seizure preceding symptoms, hypoglycemia (glucose less than 2.8 mmol/L), active malignancy with brain lesions

SCREENING TIPS

- If patient is uncooperative or cannot follow commands and you clearly witness minimal or no movements in one arm and normal or spontaneous movements in the other arm, THEN proceed to next ACT FAST step
- If both arms are similarly weak, or testing is clearly affected by shoulder problems or pain, notify ED physician

Time of Onset:

- If there is uncertainty as to time of symptom onset or whether a patient meets the ACT FAST or Acute Stroke Protocol criteria, the ED physician can contact the stroke neurologist on call for consultation
- Try to use clues to determine time last seen well – did someone talk to or call the patient?
- For suspected Wake-Up symptoms, did patient get up overnight? Were they normal when first getting up?
- Negative eligibility if time of onset is greater than 24 hours

Testing tips:

- CHAT test tips: assess patient from overall interaction and routine assessment of the patient. You can ask the patient to repeat a phrase (e.g. "You can't teach a dog new tricks") OR perform a simple task (e.g. make a fist, open and close your eyes). Use family/friends to translate.
- TAP test tips: open eyelids if required. Obvious gaze preference may be observed from the foot of the stretcher.

Implementation of the ACT-FAST Large Vessel Occlusion Screening Tool

Huron Health System



Stroke Network
Southwestern Ontario

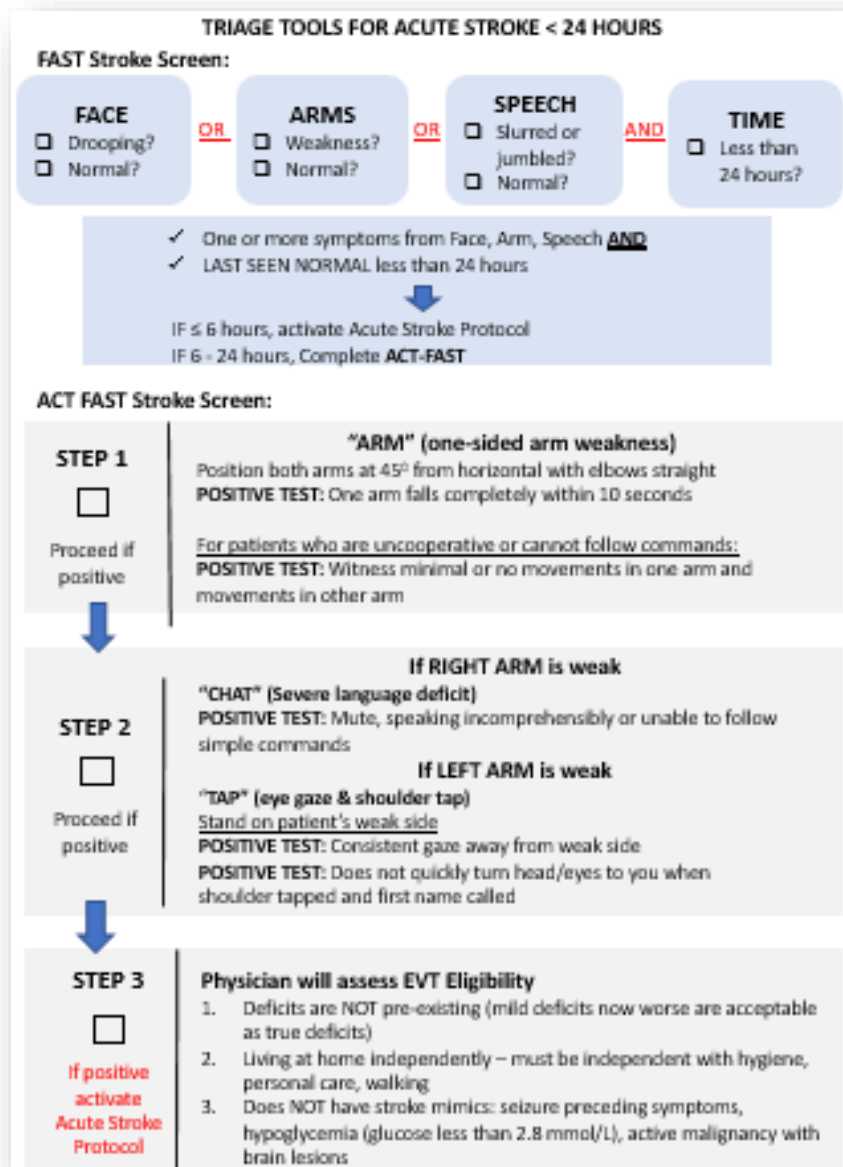
What is the ACT-FAST Large Vessel Occlusion Screening Tool?

- Stroke screening tool for 6-24 hour window
- EDs across Ontario
- High specificity and sensitivity for large vessel occlusion strokes
- ED physicians +/- triage nurses



**Rapid triage for
EVT assessment**

What is the ACT-FAST Large Vessel Occlusion Screening Tool?



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Why the Need for the ACT-FAST LVO Screening Tool?

0-4.5 hour tPA treatment window

~~0-6 hour EVT treatment window~~

0-24

NEW!

ACT-FAST tool identifies patients who might be eligible for EVT



CANADIAN STROKE BEST PRACTICE RECOMMENDATIONS

ACUTE STROKE MANAGEMENT:

*PREHOSPITAL, EMERGENCY DEPARTMENT,
AND ACUTE INPATIENT STROKE CARE*

Update 2018

*Boulanger JM, Butcher K (Writing Group Chairs), Gubitz G,
Stotts G, Smith EE, Lindsay MP
on Behalf of the Acute Stroke Management Best Practice Writing Group,
and the Canadian Stroke Best Practices and Quality Advisory Committees;
in collaboration with the Canadian Stroke Consortium
and the Canadian Association of Emergency Physicians*

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July 2018

SWOSN Toolkit Will Support Implementation

Custom screening tool

Custom process map

Posters

eLearning examples

PowerPoint Deck

Information that SWOSN Needs From Your Organization

Who will
screen?

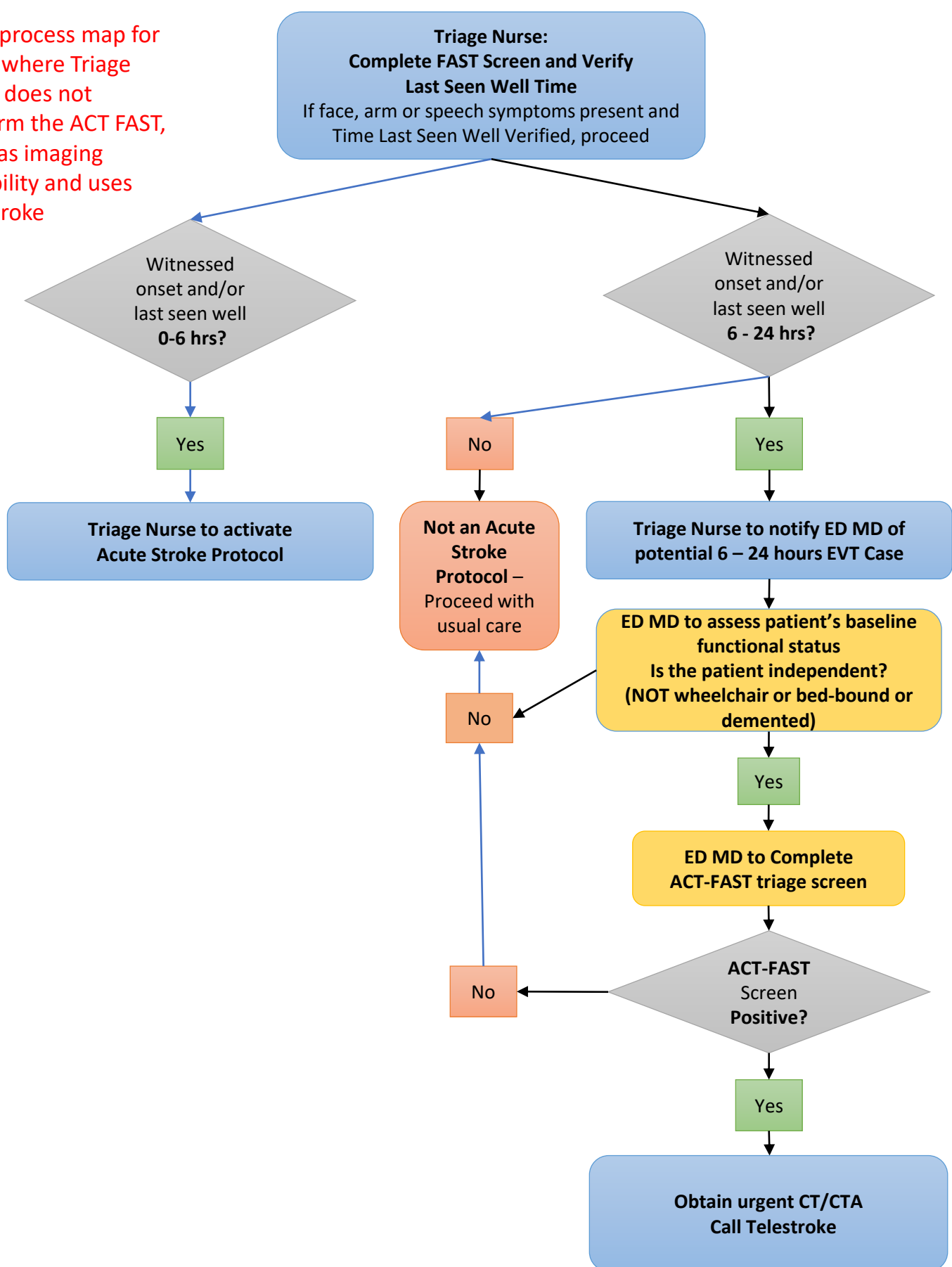
Walk-in
protocol

Imaging
capabilities

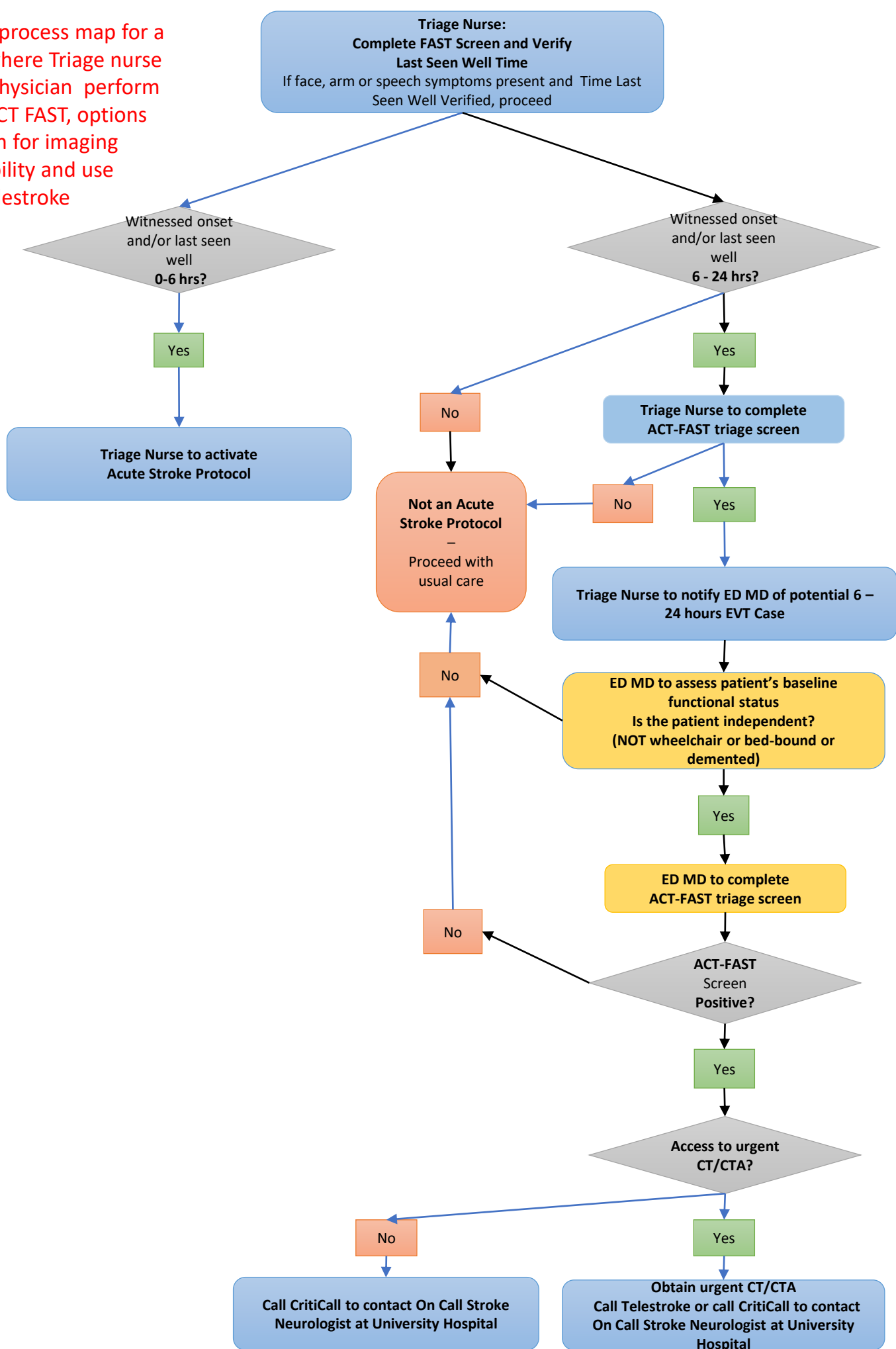
Action
required

Timeline

Draft process map for
a site where Triage
nurse does not
perform the ACT FAST,
site has imaging
capability and uses
Telestroke

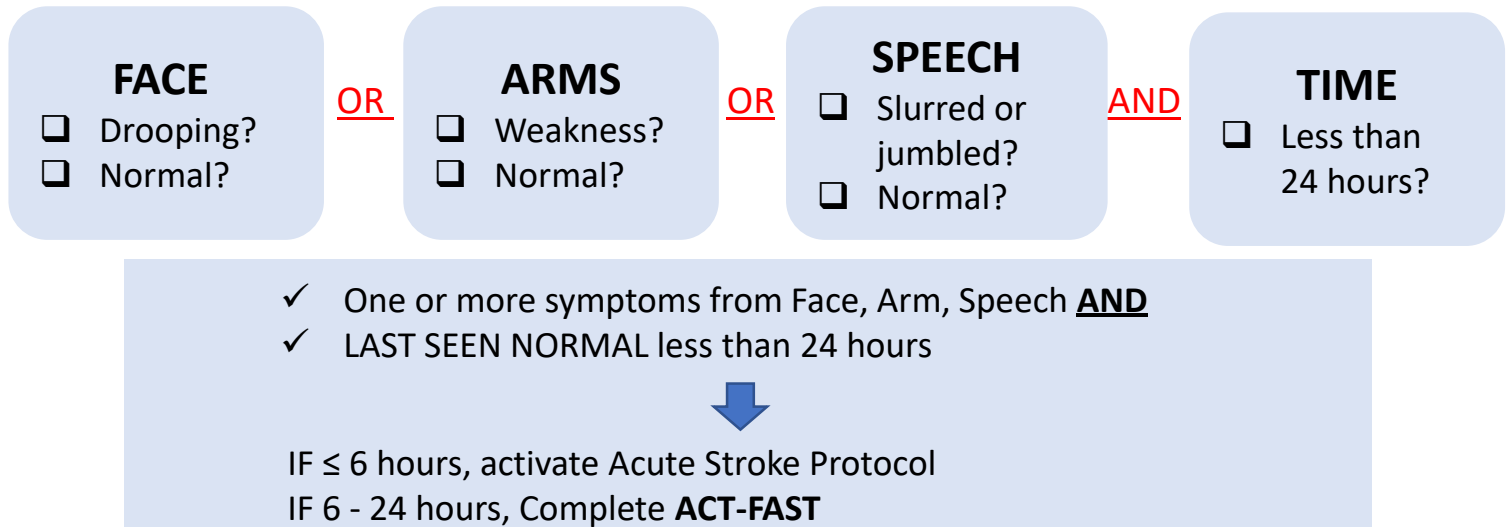


Draft process map for a site where Triage nurse and physician perform the ACT FAST, options shown for imaging capability and use of Telestroke

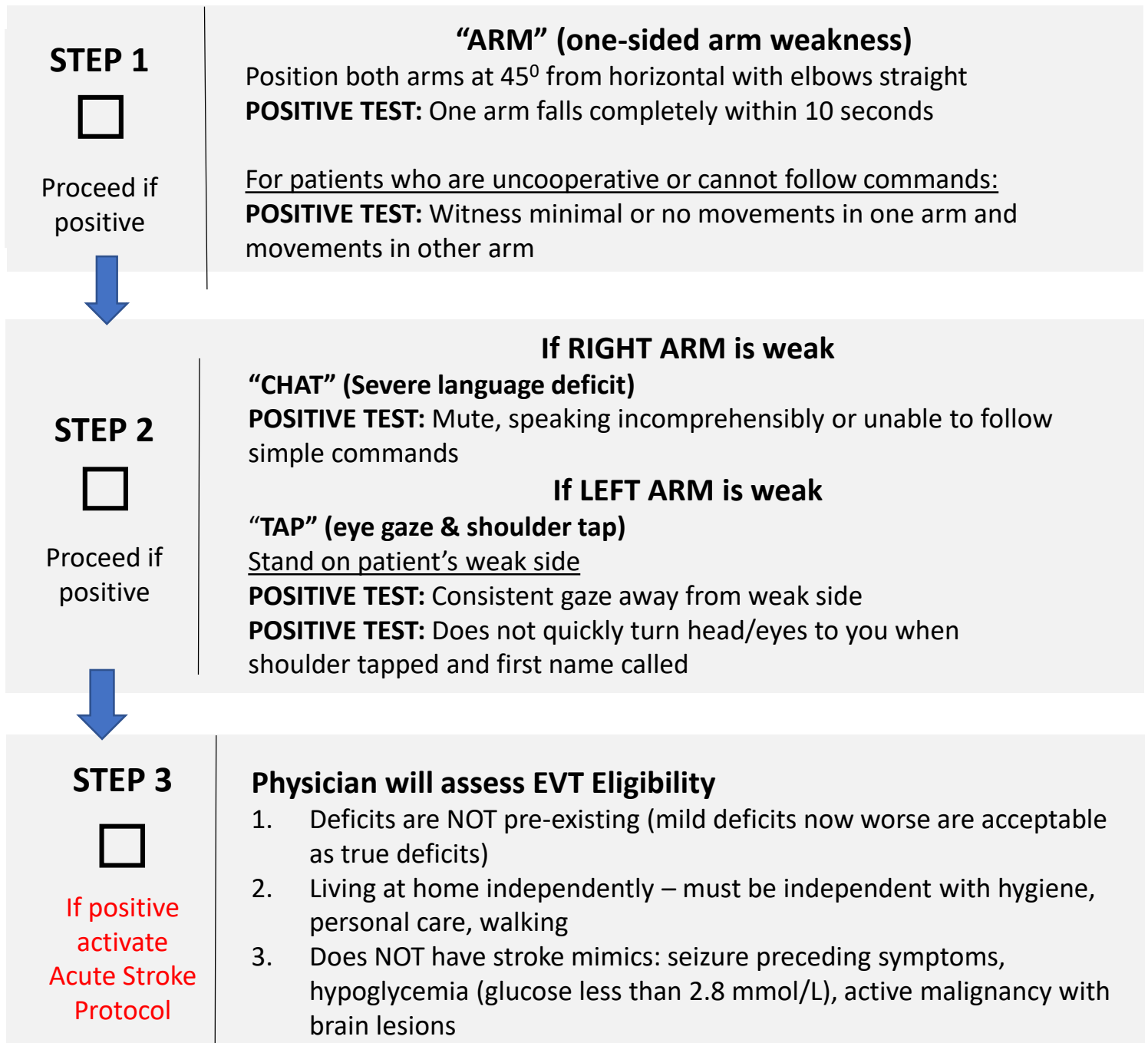


TRIAGE TOOLS FOR ACUTE STROKE < 24 HOURS

FAST Stroke Screen:



ACT FAST Stroke Screen:



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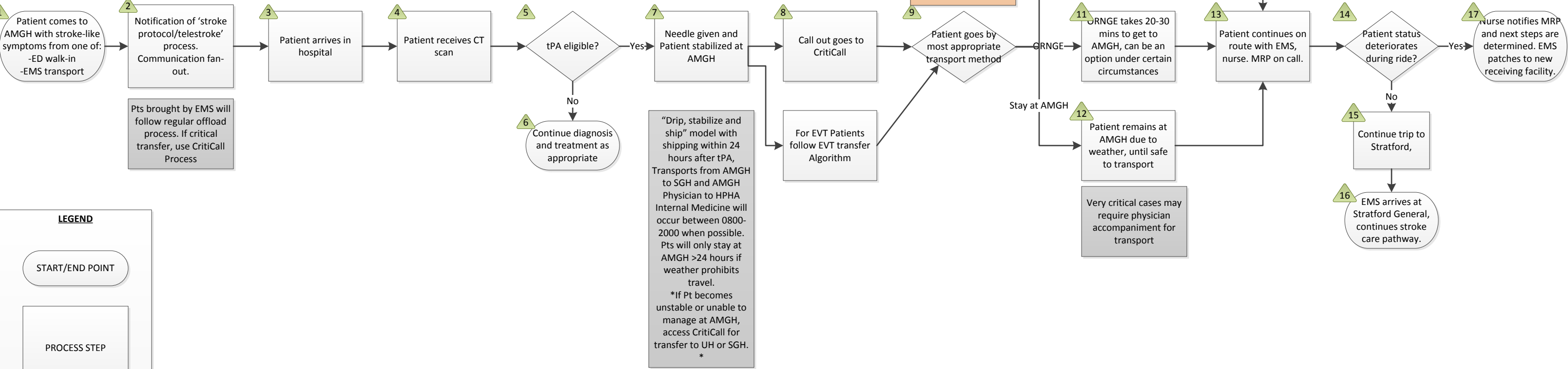
- CHAT test tips: assess patient from overall interaction and routine assessment of the patient. You can ask the patient to repeat a phrase (e.g. "You can't teach a dog new tricks") OR perform a simple task (e.g. make a fist, open and close your eyes). Use family/friends to translate.
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*This information appears on
side 2 of the ACT FAST tool*

Next Steps for Your Site

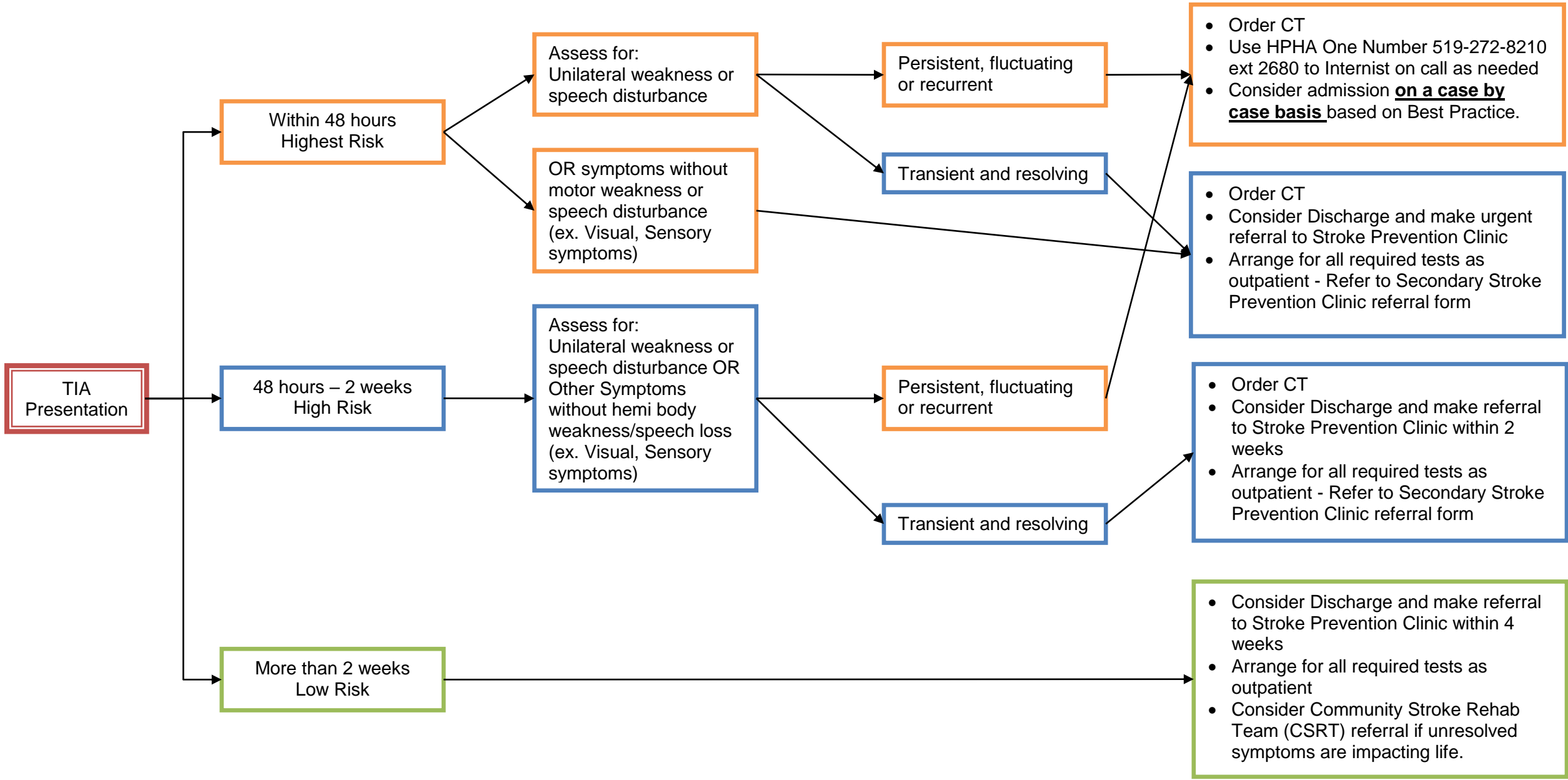
- ✓ Discuss the ACT FAST stroke screening tool with your emergency department and physicians
- ✓ Include sister sites in discussions
- ✓ DSM to provide required information to SWOSN
- ✓ Schedule education planning meeting

Drip, Stabilize and Ship Process (AMGH to Stratford General)
Updated



This is a triage tool that provides guidelines. If in doubt about how to proceed clinically, contact Stratford General Hospital One Number 519-272-8210 Ext 2680 Internal Medicine On-Call for guidance.

TRIAGE ALGORITHM FOR TIA PRESENTATION AMGH

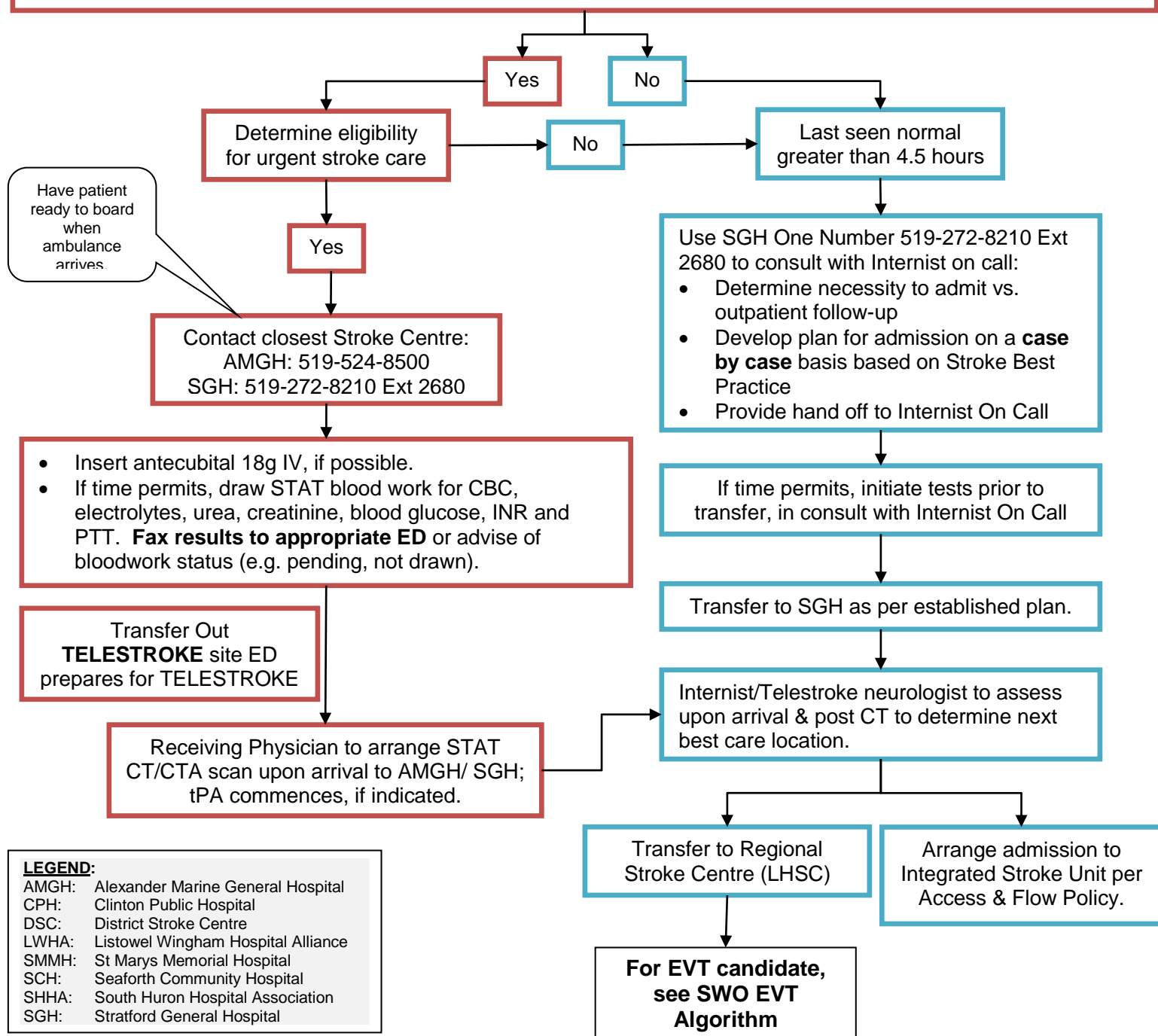


This is a triage tool that provides guidelines. If in doubt about how to proceed clinically, always contact HPHA Internal Medicine On-Call for guidance.

HURON PERTH COUNTIES ED TO ED EMERGENCY STROKE TRANSFERS

WALK-IN STROKE

- ABC's stable? (Includes finger prick for blood glucose level) ED Nurse and ED Physician triage patient. ED Physician needs to confirm symptoms and time of onset.
Assess for Sudden onset of at least one of the following:
 - Unilateral arm or leg weakness or drift
 - Slurred, inappropriate/muted speech
 - Onset of symptoms, "Last Seen Normal" **less than 4.5 hours.**
(PLEASE NOTE: Patients with disabling symptoms presenting within the 4.5 to 24 hour window may be considered for EVT)
- Patient is not terminally ill
- Patient is triaged as CTAS 2 in ED



MINUTES

Committee:	Medical Advisory Committee				
Date:	October 12 th , 2023	Time:	8:03am-9:30am		
Chair:	Dr. Mark Nelham	Recorder:	Alana Ross		
Present:	Dr. Bueno, Dr. Chan, Dr. Kelly, Dr. Lam, Dr. Mammoliti, Dr. C. McLean, Dr. Nelham, Dr. Ondrejicka, Dr. Patel, Dr. Ryan, Heather Klopp, Jimmy Trieu, Matt Trovato, Adrianna Walker, Michelle Wick				
Regrets:	Heather Zrini, Joanna Smorhay				
Guests:	Brittany Beauchamp, Shari Sherwood				
1	Call to Order / Welcome				
1.1	<ul style="list-style-type: none">Dr. Nelham welcomed everyone and called the meeting to order at 8:03am				
2	Guest Discussion				
2.1	<u>ACT-FAST Tool:</u> <ul style="list-style-type: none">Deferred to Nov				
3	Approvals and Updates				
3.1	<u>Previous Minutes</u> <ul style="list-style-type: none">Approval / Changes<ul style="list-style-type: none">None <p><u>MOVED AND DULY SECONDED</u> <u>MOTION: To accept the September 14th, 2023 MAC minutes. CARRIED.</u></p>				
4	Business Arising from Minutes				
4.1	<u>CT Scanner:</u> <ul style="list-style-type: none">Waiting for architectural drawings; anticipating to have the drawings by the end of Oct, and the submission ready for early Nov				
4.2	<u>HyperCare:</u> <ul style="list-style-type: none">Contact is Kim van Wyk; she forwarded login information to the physicians on Sep 22nd<ul style="list-style-type: none">Can be used as secure communication with Pharmacy <table><tr><td><u>Action:</u><ul style="list-style-type: none">Trial HyperCare and provide feedback / questions</td><td><u>By whom / when:</u><ul style="list-style-type: none">All; Sep/Oct</td></tr></table>			<u>Action:</u> <ul style="list-style-type: none">Trial HyperCare and provide feedback / questions	<u>By whom / when:</u> <ul style="list-style-type: none">All; Sep/Oct
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4.3	<u>Dedicated US for US Guided IV Starts:</u> <ul style="list-style-type: none">Decision to Order 1 Unit<ul style="list-style-type: none">Probes available in ED; London has visited SHH with a unit for trainingNot ordering a unit at this time				
4.4	<u>P4R Funding:</u> <ul style="list-style-type: none">P4R funding of \$150K to be spent within the remaining fiscal (6 months)<ul style="list-style-type: none">Currently considered as one-time funding, and is not guaranteed for next yearPlan for expenditure of the \$150K is due back by Oct 16th; discussed improvements and efficiencies required in the ED department<ul style="list-style-type: none">Number of patients seen in ED in later afternoon vs shift change and handover creates a bit of a bottleneck; suggested spending some of the money to increase daytime ED hours, i.e., to wrap up their patient cases, or hospitalist physician hours, i.e., to see a few ED patients, etc.<ul style="list-style-type: none">It takes approximately 45min at the beginning of shift to sort though the cases and develop a plan before patients start to move through the departmentHospital model / Admissions; addresses key performance indicator ‘percentile time to inpatient bed’Could offer 3rd year residents 3hr moonlighting blocks, although 3hrs will limit interest				

	<ul style="list-style-type: none"> ▪ Improvements around the 6 key indicators will require demonstration and tracking in order to receive the funding pot for next year ▪ Consider adding physician shifts to predictably busy days, i.e., long weekends and the Mondays / Tuesdays following, which would shorten patient ED wait times; this will increase admissions, and affect nursing workload, especially if there is a patient transfer during a shift <ul style="list-style-type: none"> ○ Suggested that ½ the funding goes to the Hospitalist position, and ½ to the ED, i.e., 1/4 day shift / 1/4 night shift; need to determine consistency in the scheduling of these hours • Burden-Based Hospital On-Call Coverage Application (BBOC) <ul style="list-style-type: none"> ○ MOH is implementing a new program to replace the existing HOCC funding; Dr. Patel is the lead on this application ○ Application is due by Nov 20th • OMA/MOH 2023 Ontario Hospital Medicine/General Medicine Survey <ul style="list-style-type: none"> ○ <i>The goal of this survey is to determine the current state of Hospital Medicine services, related patient care activities, and compensation practices across Ontario, as a framework for developing an Alternative Payment Plan (APP) for participating physicians; see link below</i> 	
	Action: <ul style="list-style-type: none"> • Develop action plan & schedule for bridging shifts • Schedule working group to review BBOC • Complete 2023 Ontario Hospital Medicine / General Medicine Survey LINK 	By whom / when: <ul style="list-style-type: none"> • Nelham / Ryan; prior to Oct 16th • Patel; Next week • All; by Oct 27th
4.5	Physician Committee Assignments & Dates: <ul style="list-style-type: none"> • 2023-10-11-Chairs & Dates of Committee Assignments for MAC included in package <ul style="list-style-type: none"> ○ There are a couple of committees that still require physician representation ○ Physician representative for each committee will provide ongoing report to MAC for minutes; aligns with accreditation needs ○ Audit and Tissue will become Chart Audit Review; addresses proper completion and closure of EMR <ul style="list-style-type: none"> ▪ Support provided by Ms. Sherwood and nursing staff 	
	Action: <ul style="list-style-type: none"> • Update and circulate committee calendar to physicians • Physician representatives to provide committee reports to MAC meetings • Seeking physician representative for Chart Audit – see Dr. Nelham 	By whom / when: <ul style="list-style-type: none"> • EA; Today • All; Ongoing • OPEN; Sep / Oct
5	Medical Staff Reports	
5.1	Chart Audit Review: <ul style="list-style-type: none"> • Future Plans and Physician Assignments <ul style="list-style-type: none"> ○ Requires a physician representative and a new process as charts are no longer paper-based 	
	Action: <ul style="list-style-type: none"> • Develop new process • Summarize at MAC 	By whom / when: <ul style="list-style-type: none"> • Physician Rep; Sep / Oct • Physician Rep; Quarterly
5.2	Death Audit Review: <ul style="list-style-type: none"> • Frequency; charts are received monthly and Dr. Patel audits them 	
	Action: <ul style="list-style-type: none"> • Summarize at MAC 	By whom / when: <ul style="list-style-type: none"> • Patel; Quarterly
5.3	Antimicrobial Stewardship: <ul style="list-style-type: none"> • Meeting held on Sep 27th; 2023-10-Antimicrobial Stewardship MAC Notes circulated in package <ul style="list-style-type: none"> ○ 1st initiative is to increase the compliance of blood cultures being drawn prior to pip-taz administration ○ Case review for: <ul style="list-style-type: none"> ▪ ‘Unpipped’ patients - 32% of patients in the last quarter that had pip-taz ordered, did not have blood cultures drawn prior to administration ▪ Patient antibiotics modified or stepped down once cultures were received 	

	<ul style="list-style-type: none"> What medications patients were on prior to c-diff diagnosis and what treatment regiment they are being put on Physicians are working on a QIP for CPSO; collecting data to create clinical pathway for common conditions, organisms and drugs used to treat infectious diseases with the purpose of providing guidance for staff on antimicrobial use based on antibiograms <ul style="list-style-type: none"> Developing recommended practice documents Anticipating developing a relationship with the new physician at HPHA who specializes in infectious diseases 		
	<table> <tr> <td> <u>Action:</u> <ul style="list-style-type: none"> Summarize at MAC If you will not be drawing blood cultures, add the reason under the order comments section </td><td> <u>By whom / when:</u> <ul style="list-style-type: none"> Zrini; Quarterly All; Ongoing </td></tr> </table>	<u>Action:</u> <ul style="list-style-type: none"> Summarize at MAC If you will not be drawing blood cultures, add the reason under the order comments section 	<u>By whom / when:</u> <ul style="list-style-type: none"> Zrini; Quarterly All; Ongoing
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5.4	<u>Lab Liaison:</u> <ul style="list-style-type: none"> Meeting held on Sep 25th; <ul style="list-style-type: none"> Determining numbers of lumbar punctures with spinal fluid sent to the lab within hospitals; not a significant number at SHH <ul style="list-style-type: none"> CSF chemistry results and a cell count can be done with the hour here Gram stains can be completed within 24hrs, and sensitivities within 48hrs Discussed push for adaption of Stratford's Massive Hemorrhage Protocol (MHP); anticipating that representatives from the group will be visiting SHH in Nov / Dec AMGH has a MHP in place; SHH will be looking at adopting this process 		
	<table> <tr> <td> <u>Action:</u> <ul style="list-style-type: none"> Develop plan for Lumbar Puncture process and retraining at SHH Seeking physician interest in attending MHP meetings – see Dr. Nelham Mock exercise </td><td> <u>By whom / when:</u> <ul style="list-style-type: none"> TBD; Revisit in Dec / Jan OPEN; Sep / Oct All; TBD </td></tr> </table>	<u>Action:</u> <ul style="list-style-type: none"> Develop plan for Lumbar Puncture process and retraining at SHH Seeking physician interest in attending MHP meetings – see Dr. Nelham Mock exercise 	<u>By whom / when:</u> <ul style="list-style-type: none"> TBD; Revisit in Dec / Jan OPEN; Sep / Oct All; TBD
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5.5	<u>Community Engagement Committee:</u> <ul style="list-style-type: none"> Dr. Ondrejicka attended the meeting on Sep 21st 		
5.6	<u>Quality Assurance Committee</u> <ul style="list-style-type: none"> Physician Assignment; next meeting Oct 18th <ul style="list-style-type: none"> Dr. Nelham will attend 		
	<u>MOVED AND DULY SECONDED</u> <u>MOTION: To approve the Medical Staff Reports as presented for the October 12th, 2023 MAC Meeting.</u> <u>CARRIED.</u>		
6	Other Reports		
6.1	<u>Lead Hospitalist:</u> <ul style="list-style-type: none"> Welcome to Dr. Jessica Mammoliti 		
6.2	<u>Emergency:</u> <ul style="list-style-type: none"> Discussed issues with timely transfer of CTAS 1&2 stroke patients for contrast imaging; transfer declined by Stratford Radiology <ul style="list-style-type: none"> A number of changes are happening around Stroke protocol, i.e., EMS handling of possible stroke patients, LAM scoring, and move from TPA to TNK, etc. Dr. Nelham has ask for a seat at the Regional Stroke Table; response pending Repairs <ul style="list-style-type: none"> One ED room pending final repairs Appreciation extended to Mrs. Vlemmix for the renovations completed in the ED; and to all of the staff and physicians who dealt with the situation Discusses pros / cons of decision made to not charge the patient for the damages 		
6.3	<u>Chief of Staff Report:</u> <ul style="list-style-type: none"> Report circulated <ul style="list-style-type: none"> Reviewed number of shifts EDLP shifts for Jul (6), Aug (6), Sep (5), Oct (4), Nov (3), and Dec (1) Discussed joining AMGH & SHH MACs in the future; not really feasible, however, there may be overlapping items that can be shared and discussed 		

	<ul style="list-style-type: none"> ○ Stressed need to get started with the Medical Clinic building plans 	
	<u>Action:</u> <ul style="list-style-type: none"> • Task for all physicians through CPSO to be completed; approximately 2hrs • Attend next Board Advance to discuss programming 	<u>By whom / when:</u> <ul style="list-style-type: none"> • All; by end of Oct • Nelham / Ryan; TBD
6.4	<u>President & CEO Report:</u> <ul style="list-style-type: none"> • Report circulated <ul style="list-style-type: none"> ○ Board will be looking at integration of the organizations throughout this coming year ○ Discussions held with Municipality around support for the establishment of a South Huron Medical Clinic <ul style="list-style-type: none"> ▪ Will be meeting with a representative of the Municipality on Friday to discuss the importance of the municipality's involvement in this opportunity ▪ Planning to form a community committee with physician, hospital, board and town representatives to review healthcare issues in the area 	
	<u>Action:</u> <ul style="list-style-type: none"> • Add community committee to next MAC agenda 	<u>By whom / when:</u> <ul style="list-style-type: none"> • EA; Nov
6.5	<u>CNE Report:</u> <ul style="list-style-type: none"> • There is significant funding available for temporary nursing positions, however, it is difficult to spend because nurses are not looking for temporary positions • Met with Ontario Health again last week and discussed need for Level 2 ICU beds at SHH; pending <ul style="list-style-type: none"> ○ Reiterated the cost of staying open and bed pressures • Trying to reduce ALC days 	
6.6	<u>Patient Experience Story:</u> <ul style="list-style-type: none"> • Report circulated 	
	<u>MOVED AND DULY SECONDED</u> <u>MOTION: To approve the Other Reports as presented for the October 12th, 2023 MAC Meeting. CARRIED.</u>	
7	New Business	
7.1	<u>Credentialing: New Appointments & Reapplications:</u> <ul style="list-style-type: none"> • Credentialing and Reappointment <ul style="list-style-type: none"> ○ Dr. Yu Li approved to start Locum Hospitalist privileges at SHH on Oct 20th, 2023; 1 reference pending 	
	<u>MOVED AND DULY SECONDED</u> <u>MOTION: To approve Dr. Yu Li, as discussed on October 12th, 2023. CARRIED.</u>	
	<u>Action:</u> <ul style="list-style-type: none"> • Forward Dr. Yu Li to HHS Common Board for final approval 	<u>By whom / when:</u> <ul style="list-style-type: none"> • EA; Nov
7.2	<u>Urgent Palliative Care Follow-Up Clinic:</u> <ul style="list-style-type: none"> • Deferred to Nov 	
7.3	<u>Removal of Hospital MLA Staff from SHH FPC:</u> <ul style="list-style-type: none"> • Due to a significant shortage of MLA staff, hours spent at the FPC for blood draws will be brought back into the hospital lab as of Jan 2024 	
7.4	<u>Cerner / MyCare Portal:</u> <ul style="list-style-type: none"> • Starting Jan 1st, 2024, all notes that are entered into Cerner will be available to patients through the MyCare Portal <ul style="list-style-type: none"> ○ Patient enrollment to the portal will start later in the year ○ All Discharge Summaries are already available to patients through the ConnectMyHealth portal going back to 2018 ○ Protected note types will be addressed as needed • The new WiFi requires that all users have an SHH account, and most physicians do not have this; physicians are currently using guest only WiFi, which has limited access <ul style="list-style-type: none"> ○ IT is identifying SHH account (active directory) and setup needs for physicians; will include access to minutes and policies 	

	<u>Action:</u> <ul style="list-style-type: none">Determine why Staff WiFi not working for physicians; need to be able to access PS SuiteDistribute eMail request for physician information needed to set up accounts	<u>By whom / when:</u> <ul style="list-style-type: none">Sherwood; TodaySherwood; Today
7.5	<u>Virtual ED Triage and Visit:</u> <ul style="list-style-type: none">Discussed; no appetite to implement this process as it poses too many issues	
8	Education / FYI	
9	Adjournment / Next Meeting	
	Date	Time
	November 9 th , 2023	8:00am
	Location	
	WebEx	
	<u>Motion to Adjourn Meeting</u> <u>MOVED AND DULY SECONDED</u> <u>MOTION: To adjourn the October 12th, 2023 meeting at 9:30am. CARRIED.</u>	
Signature		
<div></div> <div>Dr. Nelham, Committee Chair</div>		

Plan Do Study Act (PDSA) Worksheet for an Urgent Outpatient Palliative Care Clinic

Goal/ Test of Change		<ul style="list-style-type: none"> Implement outpatient palliative care clinic at the Huron Health System- Exeter Site, with Dr. Emily Kelly as the consulting physician.
Plan	Current State/ Why? Process Steps	<ul style="list-style-type: none"> Patients with no access/limited access to a family physician often present to the emergency department in crisis. Ongoing care of these patients can be fragmented and often creates repeat ER visits or hospital admissions Urgent, high-quality palliative consultation could create and communicate a care plan to the patient's healthcare providers including home care, hospice and their family physician. The goal is to complete a high-quality palliative consult on patients presenting to ER with a palliative crisis within ten days of their initial visit. Appropriate prescriptions and referrals will be made, a consultation note with plan will be dictated into Powerchart, and wherever possible, the patient will be returned to their most responsible provider for ongoing care. This plan requires no office space and minimal clerical support to register each visit as an outpatient encounter. We may be able to measure a reduction in repeat ER visits. We could reasonably achieve a goal of completing 100% of consultations within 10 days.
	Do	<ul style="list-style-type: none"> Dr. Kelly will receive referrals from the ER and book virtual or home visit consultations as appropriate by contacting the patient or their substitute decision maker. When a date for the consultation is booked, Dr. Kelly will communicate this to the outpatient clinic booking staff so that an outpatient clinic visit can be recorded in Powerchart. The consultation note and care plan will be communicated to home care, hospice or the most responsible healthcare provider (MRP). In cases where no MRP can be obtained, Dr. Kelly can continue providing palliative care to a limited number of "orphan" patients.
Do	When	<ul style="list-style-type: none"> Fall 2023
	Standard Roles/ Stakeholders	<ul style="list-style-type: none"> Will this project impact access bonuses to local family physicians? No. Neither the A945 or the K023 codes are in-basket for FHOs. The G512 ongoing palliative management fee would only be billed on orphan patients. Will making a referral be easy? Referring physicians in the ER are already overburdened by administrative referral paperwork. The referral process needs to be very simple- ideally as simple as one text sent through Hypercare, or a demographic sticker set aside in the ER. Will the referrals be appropriate? The ideal patient for this clinic is accepting of an approach to care where the primary focus is on symptom relief and functional improvement. The underlying diagnosis may be any chronic disease (ie, not just cancer), including frailty, provided that it is a survival-limiting diagnosis. Notably, the desire for ongoing chemotherapy, radiation or surgery should not exclude a patient from palliative care.
Study	Measure/ Predictions	<ul style="list-style-type: none"> Data will be captured on the quantity of these consultations and whether any impact is seen on reduced repeat ER visits or hospital admissions. Patient satisfaction with this clinic could also be captured. It is predicted that urgent palliative consultation following an ER visit would be a highly valued service to patients and their families. It may be possible to elicit feedback from local FHOs as to whether or not this clinic is valuable to them or needs some changes made.
	Evaluation of results	<ul style="list-style-type: none"> This could be accomplished at the 6 month mark after clinic implementation, again checking in with repeat ER visit/hospital admission data, patient satisfaction and feedback from community stakeholders and healthcare providers.

Act	Pilot Continued or Adjusted?	
	Sustainability	<ul style="list-style-type: none"> • ADAPT: Modifications to the referral or patient booking process may be needed. It is also important to ensure that the consultation note created on Powerchart gets communicated effectively to community stakeholders • ADOPT or ABANDON: Depending on feedback, the clinic could continue as a multi-year sustainable practice, or it could be abandoned if it is found to be redundant or otherwise not useful.

ALANA.ROSS

From: ALANA.ROSS
Sent: November 2, 2023 12:07 PM
To: ALANA.ROSS
Subject: 2023-11-02-Chairs and Dates of Committee Assignments for MAC-Medical Staff Reports

Committee	Chair	Contact	Physician Assigned	Dates
Antimicrobial Stewardship	Heather Zrini	heather.zrini@shha.on.ca	Dr. M. Nelham	<ul style="list-style-type: none">Sep 27, 2023Dec 13, 2023Mar 20, 2024Jun 26, 2024
Chart Review (Formerly Audit and Tissue)	AUDIT	cmclean7@uwo.ca	Dr. C. McLean	
Quality Assurance (Joint AMGH & SHH) (was Board Risk, Utilization) <ul style="list-style-type: none">Q1234; 3rd Wed, 4pm	Matt Trovato	mwnelham@gmail.com	Dr. M. Nelham, (SHH)	<ul style="list-style-type: none">Oct 18, 2023Jan 17, 2024Apr 17, 2024
Community Engagement Committee (Joint AMGH & SHH) <ul style="list-style-type: none">Q1234; 3rd Thu, 5pm	David Greer	greedavs@gmail.com	Dr. M. Ondrejicka	<ul style="list-style-type: none">Sep 21, 2023Dec 21, 2023Mar 21, 2024Jun 20, 2024
Health Records - Death Audit	AUDIT	neerajpatel4@gmail.com	Dr. N. Patel	
Infection Prevention & Control (Joint AMGH & SHH) <ul style="list-style-type: none">Q1234; 2nd Tue, 1pm	Jaime Murray	jaime.murray@amgh.ca	Dr. E. Kelly (SHH)	<ul style="list-style-type: none">Sep 12, 2023Dec 12, 2023
Lab Liaison Committee (Joint AMGH & SHH) <ul style="list-style-type: none">Q1234; 9am	Tim Brown	timothy.brown@amgh.ca	Dr. M. Bueno, (SHH)	<ul style="list-style-type: none">Sep 20, 2023Jan 16, 2024May 14, 2024Sep 24, 2024
MHP Committee	Tim Brown	timothy.brown@amgh.ca	occasional report only	
Pharmacy and Therapeutics	Brittany Beauchamp	brittany.beauchamp@shha.on.ca	Dr. N. Patel	<ul style="list-style-type: none">Nov 28, 2023Feb 28, 2024May 29, 2024Aug 28, 2024
Recruitment & Retention (Joint AMGH & SHH) <ul style="list-style-type: none">BiMonthly, 1st Tue, 815am	Jimmy Trieu	jimmy.trieu@amgh.ca	Dr. S. Ryan	<ul style="list-style-type: none">Sep 5, 2023Nov 7, 2023Jan 2, 2024Mar 5, 2024May 7, 2024Jul 2, 2024

INSERT

PENDING

SHH Quality Improvement Plan (QIP) Dashboard 2023-2024						
Theme/Measure	Target	Q1	Q2	Q3	Q4	Comments
Timely and Efficient Transitions						
Percentage of patients with CTAS Level I (<5 min)	100%	14%	0%			This is a data capture issue. We are meeting these targets, but the function of inputting the info up front is time consuming, leading to physicians not entering the encounter until after dealing with the patient.
Percentage of patients with CTAS Level II (<15 min)	80%	25%	28%			Same as above.
Percentage of patients with CTAS Level III (<30 min)	75%	30%	36%			Less of an issue for higher CTAS levels, as there is more time, less acute patients, so seeing the patient and entering the encounter can be done in a more timely fashion. This data is more accurate and reflective of actual performance compared to CTAS 1 and 2.
Percentage of patients with CTAS Level IV (<60 min)	70%	54%	59%			Same as above.
Percentage of patients with CTAS Level V (<120 min)	70%	82%	87%			Same as above.
Service Excellence						
Percentage of Patients discharge from acute inpatient receiving post-discharge phone call and checklist completed.	90% by Q3					We continue to develop a trackable process for this; the goal as noted in the QIP was to have this in place for the end of Q3, which we are on track to do.
Safe and Effective Care						
Percentage of completion of discharged patients receiving Discharge Medication Plan (per total number of qualifying discharged patients (no Newborn, Obstetrics, Mental Health or deceased))	90% by end of year	94.6	96			
Workplace Safety						
Completion of Public Health Safety training for leaders (either virtual or inperson).	90% by Q3	91	81			2 new/returning leaders outstanding; expect to be back in green at Q3 as they complete their newly required training.
Completion of initial workplace violence training (eLearning) within 90 days of hire.	95% by Q3					This training was re-developed and pushed out to staff in August; we are focusing our staff's attention to this (among other violence training available), and expect results to be improved by Q3.
Infection Prevention and Control						
Rate of Cdiff per 1,000 patient days	<1	2	0			Target is a maintenance target, recognizing post-COVID staff education needs; on track to meet. Established Cdiff education program. Created awareness campaign, and audit program for antibiotic usage.
Equity and Diversity						
Completion of Indigenous Cultural Safety Training by new staff and leaders.	70% by end of Q3		59			On track to meet Q3 goal, as planned. DEI module has been developed and rolled out for both sites, with education and coaching from leaders to complete.
Meets or exceeds target (100%)						
Within 25% (75-99%)		Out of target (<75%)				

Chief of Staff Report, Exeter Site – HHS Board Meeting – November 2023

Prepared by: Sean Ryan MD CCFP(EM) FCFP

I would like to start my first report with a brief introduction. For those I have not met, I have practiced full time in Exeter since 2007 in the areas of family medicine, emergency medicine and hospitalist. I have been the Chief of Emergency Medicine in Exeter for the past 6 years as well as President of the Medical Staff Association. A sincere thank you to the Board for this appointment, and I look forward to contributing what I can to our shared goals of providing high quality care to the residents of Huron County and keeping HHS relevant during a time of significant change in health care delivery. Finally, I would like to thank Dr. Mark Nelham for his strong leadership over the past 3 years during an unprecedented and difficult time for all of us in healthcare.

In terms of my specific goals for SHH over the coming years, they are as follows:

1. Physician Recruitment and Retention. This is an ongoing effort, especially for rural communities. We have had recent success in recruiting Dr. Steven Joseph to full-time practice in family and emergency medicine. He began his work at the medical clinic in September and continues to work regularly in the emergency department.
2. CT scanner. Now the standard of care for many clinical situations, this is a must-have to keep Exeter a relevant and important site for providing high quality emergency care. It will also reduce operating costs given the large amount of hospital dollars spent on transportation and nursing resources sending both emergency and inpatients to other hospitals for imaging. Finally, it will help with physician recruitment as most new graduates are uncomfortable practicing in communities without advanced imaging available.
3. Improved primary care infrastructure. This entails either a new clinic build (preferred) or the expansion of our current medical center. We are currently in a position where we cannot recruit more family physicians due to a physical lack of space. The relationship between our primary care physicians and SHH is a key reason why we have been able to sustain hospital coverage over the past several years.

4. Keeping SHH relevant. It is my belief that there are too many hospitals in the Huron Perth region. The strain on human resources and the operational costs required to keep all these sites open is unsustainable. Fortunately, both HHS hospitals are important geographically. If common sense prevails at the political level, then hospital services in Huron Perth ought to be consolidated. In this scenario, I envision Exeter being able to expand its scope of clinical service in all areas including emergency medicine, inpatient care, and outpatients. We have already seen a consistent increase in ER visits and hospital admissions over the past 2 years in association with intermittent closures of other regional emergency departments. There is also growing demand for primary care with an aging and expanding population. Without appropriate funding and resource allocation, this puts additional strain on our physicians, nurses, and administrators.

Please feel free to contact me at any time with questions or concerns. My email address is ryanse7@gmail.com

A handwritten signature in black ink, appearing to be 'Sean Ryan', with a stylized, flowing script.

Sean Ryan

PRESIDENT & CEO REPORT

November 2023

METRICS

Area	AMGH	SHHA	Comment
Health Human Resources			HHS is experience capacity issue as is the system. Clinical teams continue to monitor patient activity daily.
Master Plan and Functional Plan			Funding grant has been submitted to Ministry Capital Branch for continuation of Master Planning. Still waiting for a response.
Finance			An extension of the 2023/24 HSAA will be issued for the 2024/25 fiscal year without the need for a Performance Improvement Plan as the Ministry looks at transforming agreements to better drive provincial priorities and enable system transformation

TOP OF MIND

Fall/Winter Pressures

- Ontario is experiencing a trifecta of viruses this fall/winter season. Flu, COVID-19 and RSV are all prevalent in the community.
- 325,000 doses of COVID-19 were administered in high-risk settings and hospitals in October
- Ontario Health has identified several actions to support our collective efforts to prepare for these anticipated pressures this fall and winter and has issued an operational guidance. Highlights include:
 - Actively coordinate and support local surge, inter-region and provincial responses with Ontario Health regional teams
 - Maximize health human resource (HHR) capacity by utilizing innovative models of care and expanded scopes of practice where needed
 - Prepare surge plans to accommodate 120% inpatient capacity and increased emergency department volumes
 - Continue to prioritize ALC reduction and implement initiatives to improve access and flow while maximizing diversion strategies away from acute care
 - Aim to maintain scheduled surgeries and procedures, prioritizing patients waiting beyond clinical access targets (“long waiters”) and ramp up scheduled surgeries that do not require any inpatient footprint
- There are around 6,000 acute care beds in the West Region and Ontario Health is projecting that 6,280 beds will be required through the fall/winter
- This will place additional capacity challenges across HHS sites. The clinical leadership team continues to monitor patient activity on a daily basis and adjust staffing accordingly

BIG WINS | LEARNING

- AMGH Foundation Radiothon brought in over \$74,000 which will go towards the endoscopy program. Kudos to the Foundation and all involved for making this a great success
- BPS Guidelines are being updated and will transition to Building Ontario Businesses Initiative (BOBI) starting January 1, 2024
 - Goal is to create value & resilience for Ontarians by procuring goods and services from Ontario businesses
 - Any procurement over \$121,200 will require an open competitive process

PRESIDENT & CEO SUMMARY

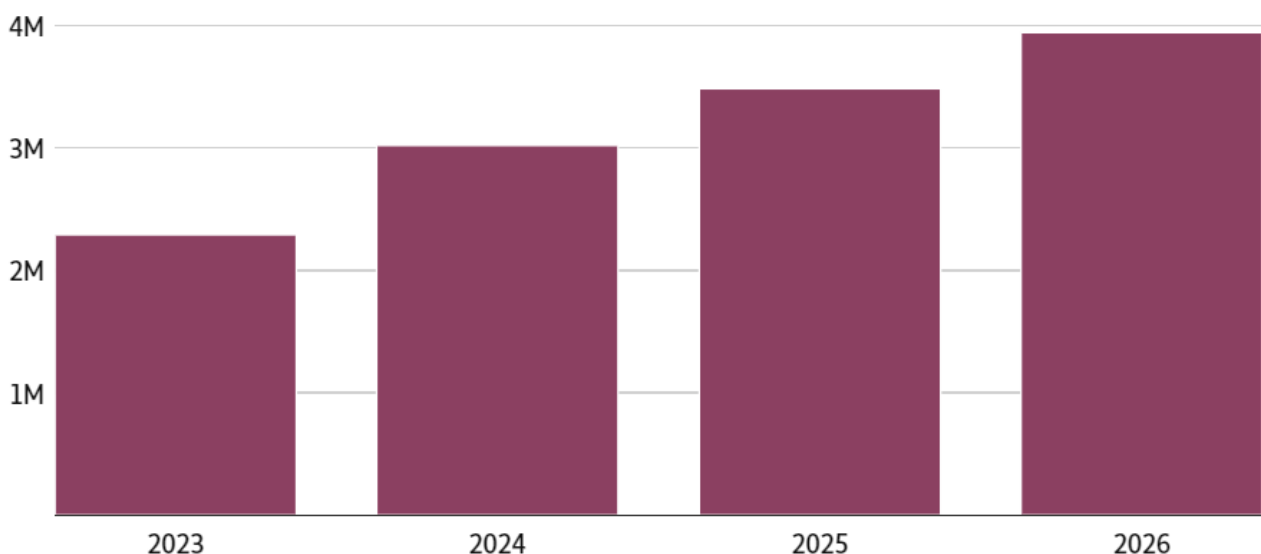
Physician recruitment continues to be a challenge across the province. New data from the Ontario College of Family Physicians indicates that more than 4.4 million Ontarians could be without a primary-care physician by 2026 as older doctors retire and younger ones turn away from traditional family practice.

New figures released Wednesday by the Ontario College of Family Physicians show an estimated 26 per cent of residents in Canada's most populous province may not have a regular primary-care provider three years from now, up from an estimated 18 per cent at the end of this year.

The college's model draws on the work of Inspire Primary Health Care, a network of family medicine researchers who use health administrative data, including Ontario Health Insurance Plan records, to forecast how looming retirements will affect supply.

Number of Ontarians without a family doctor projected to grow

In millions



SOURCE: ONTARIO COLLEGE OF FAMILY PHYSICIANS

I am working on a new recruitment and retention strategy which will be unveiled to the Recruitment and Retention Committee in the new year. This strategy will focus on a county-side approach which includes the hospital, the town, the county, the community, and subject matter experts. There is and continues to

be extreme competition for talent. HHS will need to focus on branding and what sets us apart from other hospitals. The strategy will focus on four fundamentals:

1. Developing mechanisms and processes to build a regional presence
2. Provide consistent messaging
3. Share information for simplified communications, connections and access
4. Strengthening networks and relationships

Gwen has attended several physician recruitment conferences and has garnered much interest in HHS. She continues to maintain contact with these individuals with the hope that they will come to HHS.

Respectfully,

Jimmy Trieu
President & CEO

Ontario Connecting More Women to Breast Cancer Screening Earlier

Province lowering age eligibility to receive publicly funded mammograms to include those aged 40-49

NEWS

October 30, 2023

TORONTO — The Ontario government is connecting significantly more people to breast cancer screening by lowering the eligibility age of self-referral for publicly funded mammograms through the Ontario Breast Screening Program from 50 to 40 beginning in fall 2024.

This historic expansion will help more than 305,000 people connect to important screening services to detect and treat breast cancer sooner. It is estimated that this will add an additional 130,000 mammograms that can be completed per year.

“Nearly 12,000 women are diagnosed with breast cancer each year, and we know early detection and increased access to care saves lives,” said Sylvia Jones, Deputy Premier and Minister of Health. “That is why our government is taking this important step today to expand the Ontario Breast Screening Program to connect more than 305,000 additional people to the services they need to ensure timely diagnosis and access to treatment as early as possible.”

Research has shown that regular screening, including mammography can help detect breast cancer before it has the chance to spread. By lowering the age of self-referral for mammograms, eligible Ontarians aged 40-49 who don’t have a primary care provider will be able to connect to screening more easily by self-referring through any [OBSP site](#). It also encourages more woman to have conversations with their health care provider about their risk factors and benefits of screening to determine if it is right for them.

“Expanding screening for breast cancer is another step we’re taking to build a more connected and convenient health care system,” said Peter Bethlenfalvy, Minister of Finance. “The people of this province can have confidence as our government moves ahead with our responsible and targeted approach to building a strong Ontario, that we will continue to provide better services for you and your family”.

As part of [Your Health: A Plan for Connected and Convenient Care](#), the Ontario government is connecting more people to the services they need, when they need it. Over the coming months, OBSP sites will prepare for this expansion by increasing capacity and working with the Ministry of Health to develop a public reporting tool that allows people to view appointment wait times across the province.

QUOTES:

“Supporting Ontario’s women as they continue to build our province is my top priority. We know that nothing can devastate a family or a career like a breast cancer diagnosis. That’s why we’re expanding access to care and getting women the early mammogram tests they need, so that they are empowered by better and earlier healthcare outcomes.”

Charmaine Williams, Associate Minister of Women's Social and Economic Opportunities

"Breast cancer continues to be the most common cancer among women in Canada. Although we have made great strides in improving survival rates through regular screening and early detection, lowering the self-referral age to 40 will play a critical role in increasing breast cancer survivorship for more women in Ontario. With research indicating that Black and Indigenous women are often diagnosed with more aggressive cancers at a younger age, this will also help reduce the disparities in health outcomes for equity deserving communities – ensuring that no woman is left behind."

Heather McPherson, President & CEO, Women's College Hospital

"I applaud the Ontario Government for this important announcement. Ontario will now become the largest province recognising the importance of earlier breast cancer screening. By listening and acting quickly on the advice of Ontario's breast imaging experts, the Government has made a major difference in the lives of Ontario women and their families. Screening saves lives."

Dr. David Jacobs, President of the Ontario Association of Radiologists

"It is truly a momentous occasion as the Ontario Government takes a significant step forward in health care by approving breast cancer screening for women between the ages of 40-49 promoting health equity, supporting early detection, and prioritising the well-being of women. Ontario will now be the largest province in Canada recognising the importance of earlier breast cancer screening. The benefits of this approval extend beyond medical statistics. It signifies a commitment to women's health and their right to accessible and timely health care."

Dr. Supriya Kulkarni, University of Toronto radiologist and breast imaging expert

"The Ontario Breast Screening Program provides access to screening for hundreds of thousands of people across the province each year. This transformational program expansion, being implemented next fall, will enable people ages 40 to 49 to access the benefits of the provincial screening program, which include result and recall letters and follow up."

Judy Linton, Executive Vice President Ontario Health

"As a breast cancer patient in my 40's, I have seen firsthand the many negative effects of this disease and I am so grateful that, with this announcement, other women may not have to endure the pain of a later diagnosis as I have. Research shows that early detection of breast cancer results in less aggressive therapy and reduced mortality rates – this announcement will save lives. Thank you to the Ontario government, and Minister Jones, for prioritizing women's health and making this important change."

Sherry Wilcox, Breast Cancer Patient

"I am beyond thrilled by the Ontario Government's Announcement to lower the Breast Screening Age to 40. The expansion of including women ages 40-49 will empower women to make informed decisions about how best to protect their health. As a Breast Cancer Survivor, I am reminded of the

physical, emotional, and psychological impacts of this disease daily. If you are a woman in your 40s, I strongly encourage you to get screened. Early detection saves lives."

Jennifer Quaid, Patient Advocate

QUICK FACTS

- The OBSP performs approximately 700,000 mammograms each year in Ontario.
- Screening is offered at 241 OBSP sites across the province. Find a [screening centre near you](#).
- When found early, many people survive breast cancer, with a 100 per cent, five-year relative survival rate for those diagnosed at stage 1. However, the survival rate drops to less than 30 per cent for those diagnosed at stage 4. Early detection is critical.
- With *Your Health*, the Ontario government invested \$18 million in community and surgical diagnostic centres last year to add over 49,000 hours of MRI and CT scans and over \$39 million to add 49 new MRI machines in 42 hospitals across the province.
- Through the \$61 million investment to expand the Learn and Stay grant, and with new As of Right rules, the province is historically growing the health care workforce, adding new nurses and medical laboratory technologists for years to come.

ADDITIONAL RESOURCES

[Learn more about breast cancer testing and prevention.](#)
[Learn more about the Ontario Breast Screening Program.](#)

-30-

MEDIA CONTACTS

ontario.ca/newsroom
Disponible en français

Hannah Jensen

Minister Jones' Office

Hannah.R.Jensen@ontario.ca

EMS Destination Protocol

Healthcare Concerns to be included in Protocol:

Healthcare Concern	Definition / Example of when Destination Protocol to be used
STEMI	Current protocol in existence – No change
Stroke	Current protocol in existence – No change
Orthopedic Emergencies	<p>Major Fractures including: Open, gross deformity, Hip, Long bone, Displaced ankle, spinal or pelvic</p> <ul style="list-style-type: none"> Patients with major orthopedic emergencies that EMS feel may require surgical intervention will be taken directly to Stratford Site where there is an orthopedic surgeon on-call, as long as the patient can be managed on route. Patients with minor orthopedic emergencies (i.e. isolated orthopedic injury, fractured wrist, ankle, etc.) will be taken to the closest hospital ED and followed up will occur in the outpatient clinic by the orthopedics team as per current process.
OBS/GYN Emergencies	<p>Patients over 20 weeks gestation only will be taken to OB Triage at closest site of Stratford or Listowel</p> <ul style="list-style-type: none"> Exception: Patients in active resuscitation or delivery is imminent will be taken to closest most appropriate Emergency Department. The pregnancy gestation will be determined by assessing the first day of the last menstrual period and performing the appropriate calculations
Trauma	<p>CTAS 1 – always to closest ED</p> <p>CTAS 2 – Consideration of closest hospital or larger site (Stratford, Listowel); EMS to take closures into consideration</p> <ul style="list-style-type: none"> Example: If Listowel closure – transport patient to Stratford over Palmerston
Recent Post-Surgical Hospital Discharge	Within 1 week of discharge, patients to be taken back to discharge facility if primary complaint is related to post-op condition and/or surgical site concern

Healthcare Concerns Considered But Not Proceeding with Currently:

Dialysis Emergencies	Difficult to determine in field if Dialysis related; take to closest ED
Pediatric Emergencies	Considered too unpredictable; take to closest ED for assessment
Oncology & Palliative Emergencies	Take to closest ED for assessment
Mental Health	Possible in future; would need very clear criteria as not all MH patients need a Form 1 facility
Other Miscellaneous Medical Patients	Difficult to make criteria as unknown conditions; Would be for patients where Paramedic assessment suggests higher level of care is needed. Would need a lot of education and follow-up with EMS teams if implemented in future.

SHHA Reported Incidents Review (Q3)

Board Quality Committee

January 18, 2023

I am proud to report that there are zero critical incidents to report for Q1 & 2 2023/2024. As a team that values quality care and risk reduction, we do however investigate each risk incident reported. Each risk is systemically reviewed, root causes and contributory factors are identified and risk reduction strategies are implemented. Many incidents reported result in development of an action plan and measurement strategies to evaluate the effectiveness, with the ultimate goal of system level changes that will have a lasting effect on patient safety.

Please review the Q3 summary provided of risk events which have been reported at SHHA, and the associated risk mitigation strategies that have been implemented as a result.

Severity Levels	Definitions
Reportable Circumstance	A situation in which there was a significant potential to harm, but no incident occurred
Severity Level 1	Near Miss: An incident which did not reach the patient
Severity Level 2	No Harm Incident: An incident in which an event reached a patient but no discernable harm resulted
Severity Level 3	Harmful Incident- Mild Harm: Patient outcome is symptomatic symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention is required
Severity Level 4	Harmful Incident- Moderate Harm (Potential Critical Incident): Patient outcome is symptomatic, requiring intervention, and increased length of hospital stay, or causing permanent or long term harm or loss of function.
Severity Level 5	Harmful Incident- Severe Harm (Critical Incident): Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention, shortening life expectancy or causing permanent or long term harm or loss of function
Severity Level 6	Harmful Incident- Death (Critical Incident): On balance of probabilities; death was caused or brought forward in the short term by the incident.

Critical Incident Definition:

A “critical Incident” means any unintended event that occurs when a patient receives healthcare for a health facility that,

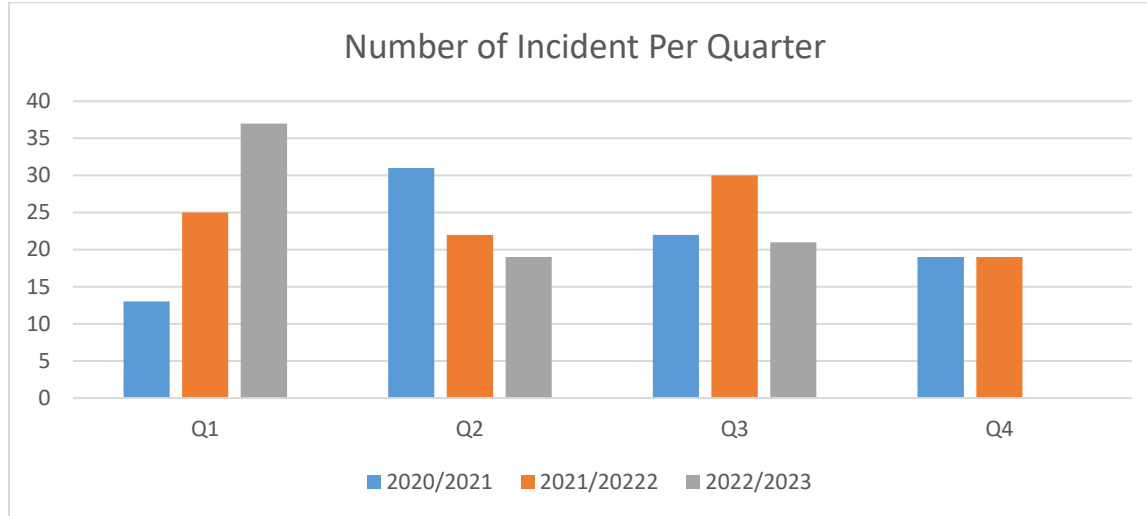
- (a) Results in death, or serious disability, injury or harm to the patient, and
- (b) Does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing health care;

(QCIPA, Public Hospitals Act).

SHHA Reported Incidents Review (Q3)

Board Quality Committee

January 18, 2023



A total of 21 incidents were reported in Q3

Emergency Department (8 incidents)

1 medication event where a home medication was entered incorrectly into the Best Possible Medication History (BPMH) as a result was ordered incorrectly. Patient received an additional dose of their medication.

Mitigation:

Clinical Informatics specialist has been reviewing root cause of medication related incidents. BPMH was noted as an area for improvement and education with nursing to improve quality and reduce errors. Nursing staff at SHHA do have access to Clinical Connect in addition to patient's prescriber and dispensing pharmacies to confirm and collect BPMH information.

2 falls, one postictal patient accompanied by wife stood up and stumbled to the ground-no injury. Second patient found lying beside stretcher on floor with pillow under head -? Unwitnessed fall. Patient assessed no injuries.

4 lab related reportable circumstances. All of which are related to IHLP glucose policy. One there 3 incidents in which a "comment code" was not selected on the glucometer, per IHLP policy for a critical result, the result was treated appropriately.

Policy: Critical Values and Lab Confirmation Note:

LOW: less than (<) 2.6 HIGH: greater than (>) 25.0 mmol/L Pediatric (less than 18yrs):

LOW: less than (<) 2.6 HIGH: greater than (>) 17.0 mmol/L

An Action Comment is mandatory for any critical value obtained on an adult: Glucometer will prompt you to select action.

1 = Repeat test

2 = LAB confirmation

3 = Deferred by HCP (Healthcare practitioner, ie. physician, midwife) Document deferral in the patient's EMR.

SHHA Reported Incidents Review (Q3)

Board Quality Committee

January 18, 2023

Mitigation:

The NOVA glucometers we use are relatively new, introduced within the past 6 months. All nursing staff have been provided education and certification on use, including IHLP policy requirements. Will provide feedback to lab re: multiple same user error incidents, to evaluate strategies for improvement.

Inpatient Medicine Unit (12 incidents)

4 falls- three level 2 falls, one patient slipped while ambulating from washroom independently. One patient rang call bell for assistance then tried to start getting out of bed and slipped off edge onto floor. Third patient lowered to the floor while ambulating with physio, as felt dizzy and subsequently had a vasovagal response. No injuries.

One Level 3 falls resulted in minor injury- patient slipped trying to stand up from chair and fell on back, resulting in hip tenderness.

2 skin/tissue incident reported- one patient developed bilateral heel ulcers while hospitalized. Interventions initiated including use of air mattress, and heel pocks. Patient was not assessed at risk as able to move freely, unanticipated patient outcome. A second patient also developed a stage 1 heel ulcer.

Mitigation

Reporting pressure ulcers that develop in hospital is relatively new for SHHA (started reporting in 2022). This is really important data to monitor quality and interventions. In early 2021 as lead by our dietitian we rolled out Nutritional Medpass aimed at improving the nutritional status of malnourished hospitalized patients, who are at risk for skin breakdown in addition to other serious implications associated with disease recovery, including prolonged hospital stay and higher treatment costs. Monitoring pressure ulcer development enables us to evaluate our current programs, and guide future practice.

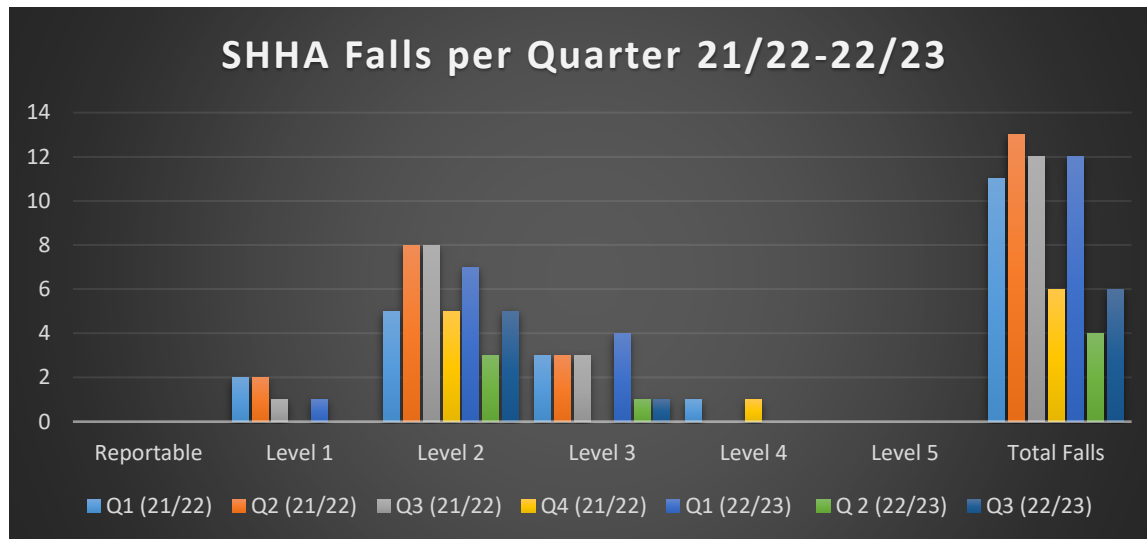
4 medication incidents- one incident nursing administered the incorrect inhaler, they used a patient "own" inhaler, and was prescribed a different medication in hospital, as such incorrect medication given. Physician ordered Lasix 200mg BID intentionally, a common dose is 20mg, pharmacist changed the dose to 20mg without confirming that the physician had entered the order in error- which they did not (tele-pharmacy night service was followed up with). Error was caught and corrected by nursing prior to reaching patient. One patient was given above the max Tylenol dose in 24 hours as patient ordered routine Tylenol and PRN tramadol (containing Tylenol) was missed in calculation. One incident 3 home medications were entered incorrectly when BPMH was entered, resulting in 3 medications being ordered incorrectly.

SHHA Reported Incidents Review (Q3)

Board Quality Committee

January 18, 2023

SHHA fall incidents (6 total)



All falls incidents were reported as level 2 or 3, with “mild harm” being the most severe falls outcome.

We are monitoring falls data at SHHA closely, as we have recently developed a falls prevention committee (2022), and are using this data in addition to reviewing incidents to evaluate our program effectiveness.

I look forward to discussing this Report, and any other items of interest in relation to quality patient care at our upcoming meeting.

Respectfully Submitted,

Michelle Wick
VP Clinical Service/Chief Nursing Executive

Patient Relations Nov 2023.

ConnectMyHealth

As many may already be aware, MyChart has been discontinued throughout Southwestern Ontario and in its place is **ConnectMyHealth**. This is a free online health records portal. Since Doctors, Nurses, Staff, Directors of the Board and their Family members are patients too, we want to boost your spirits you to sign up now!

In collaboration with Huron Perth & Area Ontario Health Team, we encourage our hospital staff, their friends and family, and the entire Huron Perth community to register to participate in this new initiative. If our hospital staff are familiar with the sign up and benefits, we will be able to encourage our patients to use this service to access their information.

Results and Reports available are: Radiology & Cardiology reports and Images, lab, pathology, genetics and microbiology results, hospital discharge summaries, allergies documented during hospital visits and some medication information. You can be notified for new results alerts.

You can check results on your desktop, laptop or mobile device safely and securely with no cost to use.

The OHT would like as many staff and physicians and Board Directors to sign up as possible, and then to help spread to the greater population. Any staff who have signed up so far have said that it is a great resource for them and they are very glad they now have the quick ability to see all of their results, at their finger tips, at no cost.

To make it secure, there is multi-factor identification software that you download first. Because of this, staff members have found that it is easier to sign up using the cell phone than the desktop. Although hospital staff don't have the time to help patients sign up, most should be able to do it. If not, the support helpline is available at <https://info.ConnectMyHealth.ca> or 1-833-824-0265.

Please note the Patient Relations challenge at hand as this and other patient portals roll out:

- London Cerner hospitals are also rolling out *MyCarePortal* where these results, as well as electronic Cerner chart notes created after January 2024 will be available. No cost to patient
- Diagnostic Imaging Results are available through *Pocket Health*. Patients can pay a fee to have access to their reports and images. At SHH, only the images can be seen – reports are not yet available.
- The various labs such as LifeLabs and DynaCare have their own patient portals where patients can sign in to see their lab results. Some charge for the service. Others don't.

Patients and staff will be confused about what is available to them and how to use it. Since we can all be patients, signing up for yourself now will ensure you have access to your own information when you want it – and you will be able to answer questions of patients and family members when you are asked.

Visit <https://info.connectmyhealth.ca> for complete information and to register for your account today!

Submitted by Heather Klopp Manager Patient Relations, Patient Registration, Privacy and Health Records.