HÔTEL-DIEU GRACE
ESTD HEALTHCARE 1888

TERMS OF REFERENCE – QUALITY COMMITTEE

Effective Date: September 2013
Last Revised Date: August 2024
To be reviewed: May 2025

Committee Oversight: *Governance*
Authorized by: Board of Directors

PREAMBLE	All standing and adhoc committees of the Hôtel-Dieu Grace Healthcare (HDGH) Board (the "Board") are established to assist the Board with workload, and are created as an advisory body to the Board, with no inherent right or role. All committee powers are derived from the Board (with the exception of those that are legislated; Medical Advisory Committee, Quality Committee and Fiscal Advisory Committee) and the regular work of all committees must be clearly identified by the Board in the annual approved work plans
PURPOSE	The Quality Committee is established by the Board of Directors as a requirement of subsection *3(1) of the Excellent Care for All Act, 2010 (ECFAA),* to act as an advisory to the Board and assist in ensuring that quality of care is an integral component of the governance management processes, and that family and patient-centred care, and patient safety related priorities are in alignment with legislative requirements, Accreditation Canada and the Strategic Plan of HDGH.

RESPONSIBILITIES	**General:**
	• Review the terms of reference for the committee annually and recommend any revisions to the Board for approval;
	• Recommend an annual work plan to the Board based on the terms of reference; and
	• Annually review, confirm and recommend revisions to the Board policies for which the Governance Committee has assigned oversight
	• Such other matters as may be referred by the Board, from time to time
	
	<u>Requirements of *ECFAA*</u>
	
	Quality Oversight and Quality Improvement:
	• Monitor and report to the Board on quality issues and on the overall quality of services provided in the hospital, with reference to appropriate data including:
	  ○ Performance indicators (scorecards) used to measure quality of care and services and patient safety
	  ○ Publicly reported patient safety indicators
	  ○ Critical incidents
	  ○ Adverse events, hospital acquired infection rates, pressure ulcers, falls, medication errors
	• Consider and make recommendations to the Board regarding quality improvement initiatives and policies;
	• Ensure that best practices information supported by available scientific evidence is translated into materials that are distributed to employees, members of the professional staff and persons who provide services within the hospital, and subsequently monitor the use of these materials by such persons;

- Oversee and recommend to the Board, approval of the hospital's annual quality improvement plan;
- Receive reports highlighting issues of patient safety, quality, patient experience, clinical outcomes and clinical quality initiatives ;
- Receive and consider recommendations form the Medical Advisory Committee (MAC), the Medical Quality Assurance Committee (MQAC), and the Quality Council (CQC) regarding systemic or recurring quality of care issues;
- Review the quality management framework, structure and its relevant program areas as required ensuring that actions are being taken to correctly identify problems and improve quality of care;
- Ensure that processes are in place to evaluate stakeholder satisfaction including, but not limited to patient satisfaction and declaration of values and any issues to be addressed; and
- Perform such other responsibilities as may be provided under regulations under the Act.

Critical Incidents:

"Critical incident" means any unintended event that occurs when a patient receives treatment in the hospital:

- That results in death, or serious disability, injury or harm to the patient; and
- Does not result primarily from the patient's underlying medical condition or known risk inherent in providing the treatment.
- The Board shall ensure that the administrator establishes a system for ensuring the disclosure of every critical incident as soon as practicable after the critical incident occurs to the patient, Substitute Decision Maker (SDM) or the patient's estate trustee as applicable. Critical Incidents are reviewed within the framework established by the Hospital which includes the Medical Quality Assurance Committee. Every critical incident is reported to the Quality Committee of the Board as soon as practicable. Plans developed to address, prevent or remediate such events are shared with the Committee.

Compliance/Risk Management:

- Monitor the hospital's compliance with legal requirements and applicable policies of funding and regulatory authorities related to quality of patient care and services;
- Financial Matters; as and when requested by the Board, provide advice to the Board on the implications of budget proposals on the quality of care and services;
- Hospital Services Accountability Agreement and Hospital Annual Planning Submission; as and when requested by the Board, provide advice to the Board on the quality and safety implications of the hospital annual planning submission and quality indicators proposed to be included in the hospital's service accountability agreement or in any other funding agreement;
- Review and make recommendations with respect to the Hospital's standards on

	emergency preparedness; • Review and make recommendations with respect to the Hospital's Integrated Risk Management Program as it relates to patient care and safety; • Ensure mitigation strategies are in place for significant organizational risks as it related to quality. **<u>Additional Role Requirements (not required by the ACT)</u>** **Accreditation:** • Monitor the hospital's plan to prepare for accreditation; and • Review accreditation reports and any plans that need to be implemented to improve performance and correct deficiencies **Professional Staff Process:** • Annually review with the chief of staff/chair of the medical advisory committee the appointment and re-appointment processes for the professional staff, including: o Criteria for appointment; o Application and re-application forms; o Application and re-application processes; and o Processes for periodic reviews. **Policy Oversight:** • Monitor the implementation of policies, processes and programs to ensure quality objectives are met and maintained; and • Review and recommend any proposed major changes to clinical programs, services as indicated by the Hospital's performance, Ontario Health strategies, legislative changes or trends in healthcare **Patient Experience:** • Receive annual report with respect to Patient Relations and complaints including an analysis of high/low performing units, performance compared to leading benchmarks and progress towards managements goals; and • Receive quarterly updates from the Patient Family Advisory Council **Ethics:** • Ensure the hospital has a process to address bioethics related issues; and • Receive management reports on the hospitals policies on bioethics related issues **Committee Performance:** • Assess and evaluate the performance and effectiveness of the Committee and Chairperson annually
MEMBERSHIP/ TERM/VOTING	**Membership:** • Chair who shall be an elected Director from among the Board (voting) • At minimum two (2), maximum four (4), additional elected members of the Board; inclusive of Patient Family Advisory Council Director(s) (voting) (at least

	1/3 of total committee membership must be voting Directors) • Chair of the Board (ex-officio non-voting) • Chief Executive Officer (ex-officio non-voting) • Chair of the Medical Advisory Committee/Chief of Staff (ex-officio non-voting) • Chief Nursing Executive (ex-officio non-voting) • Two (2) employees of the hospital who are not a member of the Ontario College of Physicians and Surgeons of the Ontario College of Nurses (ex-officio non-voting) • Non-Director Committee Members; number should not exceed the number of elected Directors (2-4)(voting) **Term**: • July 1 – June 30 • Non-director committee members serve one year terms renewable up to a total of five years **Voting**: • There shall be no proxy voting • As per the by-law (Article 4.2) electronic participation/attendance is acceptable, however email voting is not permitted
MEETINGS	Shall meet four (4) times per year from Sept – June, or more frequently as circumstances dictate. All meetings will be held in camera.
QUORUM	Shall be fixed at not less than a majority of its Directors only.
REPORTING	The Quality Committee is established under the authority of the Board of Directors and is required to report at the next regularly scheduled meeting of the Board. Minutes are recorded and available to the Board.
RESOURCES	Chief Executive Officer, Chief of Staff, Chief Nursing Executive, Director, Digital Health & PMO, Quality, Performance & Research, Chief Privacy Information Officer, Director of Corporate Services & Risk, Executive Assistant to the CEO and any additional staff required for the committee to fulfilling its duties.