ALMONTE GENERAL HOSPITAL

Quality Committee of the Board of Directors

TERMS OF REFERENCE

REPORTS TO: The Almonte General Hospital Board of Directors (the Board) and is the Quality Committee for the purposes of the Excellent Care for All Act, 2010 (ECFAA).

CHAIR: Voting member of the Board, appointed by the Board.

MEMBERSHIP AND VOTING:

Voting Members:

1. A minimum of 2 voting members of the Board in addition to the Chair (at least 1/3 of total committee membership must be voting Board members)
2. Chief Executive Officer
3. Chief Nursing Executive
4. One member of the Medical Advisory Committee selected by the Medical Advisory Committee
5. One employee who works in the Hospital, appointed by the hospital, who is not a member of the College of Physicians and Surgeons or the College of Nurses
6. Chair of the Patient and Family Advisory Committee
7. Such other persons as appointed by the Board

PURPOSE:

The purpose of the Quality Committee of the Board is to:

- Assist the Board in the performance of the Board's governance role for quality of patient care and services
- Perform the functions of the Quality Committee under the *ECFAA, 2010*
- Perform other duties as assigned by the Board of Directors

DUTIES and RESPONSIBILITIES:

The Quality Committee shall:

1. Excellent Care For All Act, 2010
   a) Monitor and report to the Board on quality issues and on the overall quality of services provided in the organization, with reference to appropriate data including:
      - Performance indicators used to measure quality of care and services and patient safety
      - Publicly reported patient safety indicators
      - Aggregate data relating to critical incident reports
      - Aggregate data relating to the patient relations process
      - Reports received from the Medical Advisory Committee identifying and making recommendations with respect to systemic or recurring quality of care issues

   b) Consider and make recommendations to the Board regarding quality improvement and risk management initiatives and policies.

c) Ensure that best practices information, supported by available scientific evidence, is translated into materials that are distributed to employees and persons providing services within the healthcare organization, and to subsequently monitor the use of these materials by these people.

d) Oversee the preparation of the organization's annual quality improvement plans[1] (AGH and FVM) having regard to:
- results of surveys
- data related to patient relations process
- aggregate critical incident data
- performance agreements and obligations to the Ministry of Health & Long Term Care (MOHLTC), Champlain Local Health Integration Network (LHIN) and other relevant legislative and/or regulatory requirements

e) Oversee the preparation of the hospital's Senior Friendly Hospital Improvement Plan having regard to:
- Completed Senior Friendly Hospital Self Assessments as well as the individualized improvement letters received from the Champlain LHIN;
- The *Senior Friendly Hospital Care Across Ontario* provincial report at: http://champlainlhin.on.ca/Page.aspx?id=1184#Senior_Friendly_Hospital;
- The Senior Friendly Hospital *Promising Practice Toolkit* available at http://seniorfriendlyhospitals.ca/.

f) To ensure that the organization provides a draft of the Board approved annual quality improvement plan to the Champlain LHIN for review before it is made available to the public.

g) To ensure that the organization makes the annual Quality Improvement Plan available to the public after approval by the Board and the LHIN.

h) To ensure that the organization submits a copy of the approved annual quality improvement plan to Health Quality Ontario (HQO) in the format provided by HQO.

i) To perform such other responsibilities as may be provided under regulations under ECFAA, 2010.

2. <u>Accreditation</u>
- Oversee the Hospital's plan to prepare for accreditation.
- Review accreditation reports and any plans required to be implemented to improve performance and correct deficiencies and monitor progress against plans.

[1] The manner in and extent to which executive compensation is linked to achievement of the performance targets will be determined by the Executive Committee of the Board and will be reflected in the Quality Improvement Plan.

3. Critical Incidents
    - Review at least twice a year, aggregated critical incident data related to critical incidents occurring at the Hospital since the previous aggregate data was provided to the Committee.
    - Annually review the Hospital's process for ensuring the appropriate disclosure and follow up of critical incidents in accordance with Regulation 965.
4. Risk Management
   Review and make recommendations with respect to policies for risk management related to quality of patient care and safety.
5. Oversee and review the activities performed by the Patient and Family Advisory Committee.
6. Committee meetings will include a standing agenda item to review feedback of the patient experience.
7. Other
    - To perform such other duties as may be assigned by the Board from time to time.
    - To review the Board Quality Committee Terms of Reference annually

FREQUENCY of MEETINGS:
Monthly, or at the call of the Chair, or as determined by the Committee to fulfill the Committee's mandate.

QUORUM:
A majority of voting members.

RESOURCES:
The Recording Secretary is the Senior Administrative Assistant to the Vice Presidents.

REPORTING:
The Quality Committee shall report to the Board at each meeting of the Board and shall annually prepare and provide a report to the Board that provides an overview of the activities of the Quality Committee over the previous year

Minutes shall be distributed to all members. Master copies of the minutes shall be stored in the Administration office.

PRIVILEGE AND CONFIDENTIALITY:
Information provided to, or records prepared by, the Quality Committee for the purpose of assessing or evaluating the quality of health care and directly related programs and services provided by the hospital are subject to an exemption from access under the *Freedom of Information and Protection of Privacy Act.*

REFERENCES:

1. Excellent Care for All Act, 2010, S.O. 2010, c.14 -Bill 46 obtained August 13, 2013 from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_10e14_e.htm
2. Public Hospitals Act, R.R.O, 1990, Regulation 965 obtained August 13, 2013 from: http://www.elaws.gov.on.ca/html/regs/english/elaws_regs_900965_e.htm
3. Public Hospitals Act – O.Reg.445/10 obtained August 13, 2013 from: http://www.e-laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10445_e.htm
4. Quality and Patient Safety Governance Toolkit, 2011. *1.4 Quality Committee Terms of Reference* obtained August 2, 2013 from: http://www.oha.com/KnowledgeCentre/Library/QPSGT/Documents/Quality%20and%20Patient%20Safety%20Governance%20Toolkit%20-%20All%20Sections.pdf