YORK CENTRAL HOSPITAL CORPORATE QUALITY OF CARE COMMITTEE
TERMS OF REFERENCE

Preamble:

The Corporate Quality of Care Committee is designated by the Board of York Central Hospital as a Quality of Care Committee under The Quality of Care Information and Protection Act, 2004 (QCIPA) and has been created by Board Resolution.

QCIPA will promote quality care and patient safety at York Central Hospital by enabling it to carry out a review of any incident or event with the assurance that the information generated by the review is protected from disclosure.

Purpose:

This is the quality of care committee with overall responsibility for quality of care reviews related to critical incidents within the hospital. The purpose of the Corporate Quality of Care Committee is to carry on quality of care reviews for the purpose of studying, assessing or evaluating the provision of health care with a view to improving or maintaining the quality of health care, or the level of skill, knowledge and competence of the persons who provide health care.

Functions:

To determine what types of situations should be reviewed under QCIPA especially matters which may give rise to significant quality of care concerns including all critical incidents:

- An occurrence involving an unexpected death or serious bodily harm
- An occurrence or series of occurrences that have the potential to result in death or serious bodily harm

Depending on the matter to be reviewed, the Committee may seek or receive information/reports from any hospital staff member, committee and/or external person/entity by designating them under the protection of QCIPA if a Quality of Care review is warranted. The information generated by the review is protected as the other committee or individual is engaged in the review as a delegate of the Corporate Quality of Care Committee.

Personal health information can be disclosed without the patient’s consent to a quality of care committee for the purposes of the committee.

The Committee will provide timely reports pertaining to critical incidents to the CEO and the Medical Advisory Committee.

The Committee facilitates quarterly reports on critical incidents to the QPM subcommittee of the Board via the MAC and CEO.
The Committee is responsible to develop, review; revise all policies and procedures related to incident reporting, investigation and disclosure as per the Public Hospital’s Act, the Quality of Care and Information Act and other emerging applicable legislation.

The Committee shall ensure that aggregate critical incident data is compiled which will be used in the development of the organization’s quality improvement plan.

**Review/Follow Up:**

For reviews conducted outside of QCIPA the Committee shall provide a timely report to the CEO, MAC, and the patient.

The reports should contain:
- A description of the incident and the circumstances
- Consequences for the patient
- Actions taken and recommended to address the consequences to the patient including any systemic changes to the hospital undertaking to avoid or reduce the risk of other similar critical incidents

For reviews conducted under QCIPA, the Committee may disclose information (this may include recommendations and any other information) to management if the Committee considers that it is necessary for the purpose of improving or maintaining the quality of health care provided at the hospital for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons. The committee will disclose to the patient the systemic steps, if any, actually taken by the hospital.

The Committee has overall responsibility for the follow up of any recommendations arising out of critical incident investigations and may assign responsibility to the hospital Quality Council, other committees, programs and services as it deems appropriate.

**Information to the Committee:**

All incidents that meet the criteria for review are reported to the Senior Quality of Care Committee through the Director Quality/Risk/Patient Safety. The Committee shall decide:
- If the incident meets the threshold criteria for critical incident
- If the incident shall be investigated under QCIPA and/or
- Whether the incident would best be reviewed by another committee or individual and then delegate to the other committee or individual to carry out the particular review.

**Membership: (chair TBD)**

Chief of Staff
VP Patient Care Services, Chief Nurse Executive
Chief Practice Officer
Director Quality, Risk, Patient Safety

**Accountability:**

The Senior Quality of Care Committee is accountable to the CEO.
Frequency of Meetings

At the call of the chair and within 1 week of the critical incident being identified. A minimum of 3 members are required to hold a meeting.

Review:

The Committee shall review these terms of reference on an annual basis and as needed.