BOARD MANUAL

SUBJECT: Quality Committee Terms of Reference	**NO.: 2-A-18**
SECTION: Structure, Roles and Responsibilities	
APPROVED BY: Board of Directors	**DATE: December 4, 2024**

1. Application

These Terms of Reference shall apply to the Quality Committee (the "**Committee**") of the Board of the Cambridge Memorial Hospital (the "**Corporation**"). All capitalized terms not defined herein have the meaning set out in the Corporation's By-Laws.

2. Definitions

The "Quality Committee" operates under the authority of the Board and is the Quality Committee for the purposes of the *Excellent Care for All Act, 2010* ("the Act").

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

"Performance Metrics" means the Board approved organization performance metrics that provide an overview of the organization's performance in achieving quality, workplace safety as it relates to a quality metric, patient and staff satisfaction and such other performance metrics that the Board may approve from time to time.

3. Composition

(a) The Committee shall consist of the following voting members:

(i) up to five (5) voting members of the Board to ensure, pursuant to the regulations under the *Excellent Care for All Act* that one third of the members of the Quality Committee are voting members of the hospital board, one of whom shall be appointed Chair;

(ii) up to four (4) members from the broader community who are resident, employed or carrying on business in the Region of Waterloo, appointed by the Board upon the recommendation of the Governance Committee;

(iii) a member of the Patient Family Advisory Committee (PFAC), appointed annually by PFAC;

(iv) the President and Chief Executive Officer (CEO);

(v) one member of the Medical Advisory Committee;

(vi) the Chief Nursing Executive; and

(vii) up to two hospital employee(s) who are not members of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario.

Subject to the approval of the Board, the members of the Quality Committee referenced at paragraphs (iv) and (vi) may appoint a delegate to sit as a member of the Quality Committee in their stead.

(b) Non-voting resources to the Committee will include:

(i) VP People & Strategy; and

(ii) any other staff resources identified by the CEO in consultation with the Committee Chair.

(c) Members will be appointed annually by the Board with consideration given to re-appointing some members each year for the benefit of their knowledge and experience gained on the Committee.

4. Meetings

The Committee shall:

(a) meet at least four (4) times annually, or more frequently as circumstances dictate

(b) conduct all or part of any meeting in the absence of management, and, at a minimum, conduct such a session at each regularly scheduled Committee meeting.

(c) invite to its meetings any Director, member of management or such other persons as it deems appropriate in order to carry out its duties and responsibilities

(d) exclude from its meetings any persons it deems appropriate in order to carry out its responsibilities

5. Specific Duties and Responsibilities

(a) *Excellent Care for All Act, 2010*

The Committee, in accordance with its responsibilities under the Act, shall:

(i) monitor and report to the Board on quality issues and on the overall quality of services provided in the Corporation, with reference to appropriate data including:

(a) Performance Metrics and other performance indicators used to measure quality of care and services and patient safety;

(b) reports received from the Medical Advisory Committee identifying and making recommendations with respect to systemic or recurring quality of care issues;

(c) publicly reported patient safety indicators;

(d) critical incident; and

(e) annual program reviews of quality.

(ii) consider and make recommendations to the Board regarding quality improvement initiatives and policies;

(iii) 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 health care organization, and to subsequently monitor the use of these materials by these people;

(iv) oversee the preparation of the Corporation's annual quality improvement plans;

(v) review and report to the Board on progress in achieving the goals of the quality improvement plan and the quality and safety plan;

(vi) oversee the establishment and monitoring of the patient declaration of values in collaboration with the Patient and Family Advisory Council;

(vii) oversee that a process is in place to collect and monitor patient and employee satisfaction (including staff and other persons working for or providing services within the organization), monitor the results of such surveys and, where applicable, the incorporation of the findings into the quality improvement targets;

(viii) develop and oversee the implementation of a policy that requires the posting of Board approved quality Performance Metrics and targets on the

Corporation's public website; and

(ix) perform such other responsibilities as may be provided under regulations under the Act.

(b) Accreditation
The Committee shall:

(i) oversee the Corporation's plan to prepare for hospital-wide accreditation and, as relevant, for department/program specific accreditations; and

(ii) review accreditation reports and any plans required to be implemented to improve performance and correct deficiencies.

(c) Critical Incidents
The Committee shall:

(i) in accordance with Regulation 965 under the *Public Hospitals Act* receive from the Chief Executive Officer, at least twice a year, aggregate critical incident data related to the critical incidents occurring at the hospital since the previous aggregate data was provided to the Committee and the actions taken to mitigate the risks associated with any such incidents; and

(ii) annually review and report to the Board on the Corporation's system for ensuring that, at an appropriate time following the disclosure of a critical incident, there be disclosure as required by Regulation 965 under the *Public Hospitals Act* of the systemic steps, if any, the Corporation is taking or has taken to avoid or reduce the risk of further similar critical incidents.

(d) Oversight of Risk
The Committee shall:

(i) oversee risk management in the following assigned categories: accreditation, care, regulatory and teaching; and

(ii) oversee the appropriate progress and completion of plans to mitigate risks identified through the integrated risk management priority setting process and report annually to the Audit Committee.

(e) Organ Donation
The Committee shall:

(i) ensure that procedures are in place to encourage the donation of organ and tissues in accordance with the Board's responsibilities in the regulations under the *Public Hospitals Act*

(f) Professional Staff Process
The Committee shall:

(i) Review at least every 3 years with the Chief of Staff the appointment and re-appointment process for the professional staff, including:

- Criteria for appointment;
- Application and re-application forms;
- Application and re-application process; and
- Processes for periodic review

6. General

The Committee shall have the following additional general duties and responsibilities:

(a) assisting the Board in the performance of the Board's governance role for the quality of patient care and service and reporting to the Board at each of its meetings;

(b) as and when requested by the Board, providing advice to the Board on the implications of budget proposals on the quality of care and services;

(c) as and when requested by the Board, providing advice to the Board on the quality and safety implications of the Hospital Annual Operating Plan and quality indicators proposed to be included in the Hospital's Service Accountability Agreement or in any other funding agreement;

(d) suggesting Board education and development relating to quality topics appropriate for Board level discussion and oversight;

(e) maintaining minutes or other records of meetings and activities of the Committee;

(f) having the authority, upon approval by the Board, to engage independent legal counsel, consultants, or other advisors with respect to fulfilling its responsibilities and the Hospital corporation shall provide appropriate funding;

(g) conducting an annual evaluation of the Committee in which the Committee (and/or its individual members) reviews the Committee's performance for the preceding year for the purpose, among other things, of assessing whether it fulfilled the purposes and responsibilities stated in this Terms of Reference;

(h) providing an orientation for new committee members;

(i) assessing the adequacy of this Terms of Reference at least every three (3) years and submitting any proposed amendments to the Governance Committee and the Board for approval; and

(j) performing such other functions and tasks as may be assigned from time to time by the Board.

DEVELOPED: September 28, 2011		
REVISED/REVIEWED:		
May 29, 2013	October 30, 2013	May 27, 2015
May 24, 2017	January 29, 2020	May 26, 2021
November 30, 2022	January 25, 2023	March 1, 2023
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