No. QM-80	
Title: Quality of Care Reviews	☒ **Policy** ☐ **Procedure** ☐ **SOP**
Category: General **Sub-category:** Quality and Risk Management	**Distribution:** Organization Wide
Endorsed: President & CEO **Signature:**	**Approval Date:** Sept. 6, 2005 **Reviewed/Revised Date:** Jan. 9, 2026 **Next Review Date:** Jan. 9, 2029

CROSS REFERENCES: (QM-60) Incident Learning System (ILS): Reporting, Investigation and Trending of Incidents and Near Misses, (QM-70) Mandatory Disclosure of Harm/Critical Incidents, (PS-40) Morbidity & Mortality (M&M) Reviews

1. PURPOSE

Provide an overview of the Quality of Care Review process.

2. POLICY STATEMENT

Thunder Bay Regional Health Sciences Centre (the Hospital) supports the identification, reporting, investigation, and addressing of critical incidents. The organization supports a *Just Culture* where open incident or near miss reporting and review of patient safety events are encouraged by all staff, professional staff and learners.

3. SCOPE

All staff, professional staff and learners.

4. DEFINITIONS

Clinical Debrief (aka "Hot Debrief")
Following a critical incident or code, a meeting to summarize the case, determine what went well and opportunities for improvement, and highlight where actions are required, which occurs within minutes to hours of the event, while emotions, reactions and impressions are still “hot”.

Critical Incident – In accordance with Regulation 965 of the Public Hospitals Act:
Any unintended event that occurs when a patient receives treatment in a hospital,
a) that results in death, or serious disability, injury or harm to the patient; and
b) does not result primarily from the patients’ underlying medical condition or from a known risk inherent in providing the treatment.

Incident Triage Team (ITT)
A group of leadership consisting of Quality and Risk Management (QRM), Chief Nursing Executive, Chief of Staff, Most Responsible Provider (MRP) or Chief of Department, and Manager or Director of Department, who will meet within 48-72 hours of a critical incident occurring to determine if a QOC Review is required, and if so, what type of review.

Quality of Care (QOC) Reviews
QOC Reviews are completed following an incident (or near miss with potential for patient harm) to identify opportunities for improving quality and patient safety. The purpose of a review is to identify and address systemic issues, not to focus on individual performance. These reviews are further defined as:

- Departmental Reviews (led by Departmental Leadership);
- Morbity & Mortality (M&M) Reviews (led by Professional Staff – see PS-40);
- Critical Incident and Process Reviews for systemic issues (led by Quality and Risk Management).

Quality of Care Information Protection Act (QCIPA)

The *Quality of Care Information Protection Act, 2016* (QCIPA) allows health professionals to have open discussions about critical incidents involving patient care and quality improvement matters in general. The goal of QCIPA is to create a safe space for health professionals to talk openly about quality improvement, including the potential cause of any critical incidents, without fear that the information will be used against them.

5. PROCEDURE

5.1. Request for QOC Review

A QOC Review can be requested by anyone within the organization by notifying the Director of QRM. The decision of whether a review will be covered under QCIPA is determined by the ITT, with final decision by the Quality of Care Committee or the Chair as designate. All reviews, QCIPA or non-QCIPA protected, should be reported to QRM.

5.2. QCIPA protected reviews are undertaken for the following events:

1. any incident that is expected to cause negative publicity or harm to the Hospital's reputation;
2. any event that is expected to lead to a medical-legal claim.

5.3. Non-QCIPA reviews will be done in instances where the review does not require protection under the QCIPA as determined by the ITT, with final decision by the Quality of Care Committee or the Chair as designate. Non-QCIPA reviews are undertaken for the following events:

1. any event that is not expected to cause negative publicity or harm to the Hospital's reputation;
2. any event that is not expected to lead to a medical-legal claim;
3. single department process review unrelated to a critical incident.

6. PROCESS

6.1. Review of Incident

Incidents/patient harm events are reviewed promptly and consistently utilizing the *Incident Review Process Flowchart* in **Appendix A**.

6.2. Clinical Debrief

It is ideal if a Clinical Debrief (or "Hot Debrief") can be facilitated as soon as possible after the event with those who were immediately involved. Participation is voluntary.

6.2.1. During regular work hours, the debrief should be led by the Manager or MRP, or after hours by the Unit Lead supported by the Administrative Coordinator as needed, using the standardized debriefing approach of **S.T.O.P.** → **S**ummarize the case – **T**hings that went well – **O**pportunities to improve – **P**oints of action (see **Appendix B** for guide).

6.2.2. Conversation points should be documented in the *Clinical Debrief Tool* by one person in the group (see **Appendix C** for tool) other than the person leading it.

6.2.3. The target duration of a Clinical Debrief is 15 minutes, though could go longer if staff present feel it necessary.

6.2.4. The debrief should end with agreement on who will enter a patient safety incident report in the Incident Learning System (ILS).

6.2.5. The completed debrief tool describing any follow up actions required will be provided to the unit Manager / Department Head following the debrief to help with the review and investigation of the event.

6.3. Classification of Incident

Within 24 hours of the incident (or if incident occurs on a weekend, by Monday morning), the Manager / Department Head will review the ILS incident report, and the debrief tool if applicable, and determine if the incident is a critical incident, a potential critical incident or a never event.

6.3.1. If yes, the Manager / Department Head must contact the QRM Director (or Senior Leader on call after hours), the Program Director and the MRP.

6.3.2. If not, the Manager / Department Head will continue with the usual review and follow-up of the incident (reference QM-60).

6.4. Decision-Making by ITT

The decision to complete a full QOC Review will be the responsibility of the Quality of Care Committee or the Chair as designate, in consultation with the ITT.

6.4.1. The QRM Director (or delegate) will schedule a meeting of the ITT within 48 hours of the incident to confirm if a QOC Review is required (or 72 hours if the incident falls on a weekend).

6.4.2. The ITT will confirm the following information (to be documented in the *Critical Incident Triage Log* by QRM – see **Appendix D**).

1. a review is required;
2. initial disclosure occurred;
3. the review type;
4. the most responsible leader;
5. if QCIPA is required;
6. the review team/participants.

Note: Regardless of review type, the review will take place within **60 days** following the identification of the event.

6.5. QOC Review Team/Participants

6.5.1. The mandate of the team participating in the QOC Review is to:

1. review the chart, related documents and any relevant policies/procedures, protocols and standards prior to attending the review;
2. interview staff, professional staff and learners as necessary for further information or clarification;
3. recommend prevention strategies;
4. identify recommendations that can minimize reoccurrence or serious consequences;
5. ensure that appropriate timelines are included in next steps;
6. ensure accountabilities are assigned;
7. communicate the recommendations back to relevant collaborators and the Quality of Care Committee.

6.5.2. All reviews should include:

- The responsible Manager(s);
- Chief of Service (if applicable);
- Involved staff, professional staff and learners;
- Other representatives as appropriate.

6.6. QOC Review Documentation

All QOC Review documents will be marked as follows:

"Privileged and Confidential Quality of Care Document"
"DO NOT COPY OR CIRCULATE"

6.7. QOC Review Reporting

Each review team will have documented a summary of recommendations and any subsequent changes made as a result of the review. All final recommendations should be shared with QRM and key collaborators. Formal reporting will occur as follows:

1. Departmental leadership;
2. Medical Advisory Committee (MAC) – Medical Quality Assurance Sub Committee and Quality of Care Committee—all critical incident review recommendations go to the next booked MAC meeting and should occur within 90 days of the incident.

3. All recommendations go to Quality of Care Committee following review by MAC (if applicable).
4. Aggregate reports are brought to the Quality Committee of the Board twice per year.
5. Recommendations from critical incident reviews will be shared with the Patient / Substitute Decision Maker / Executor of Will as requested.

6.8. Confidentiality under QCIPA

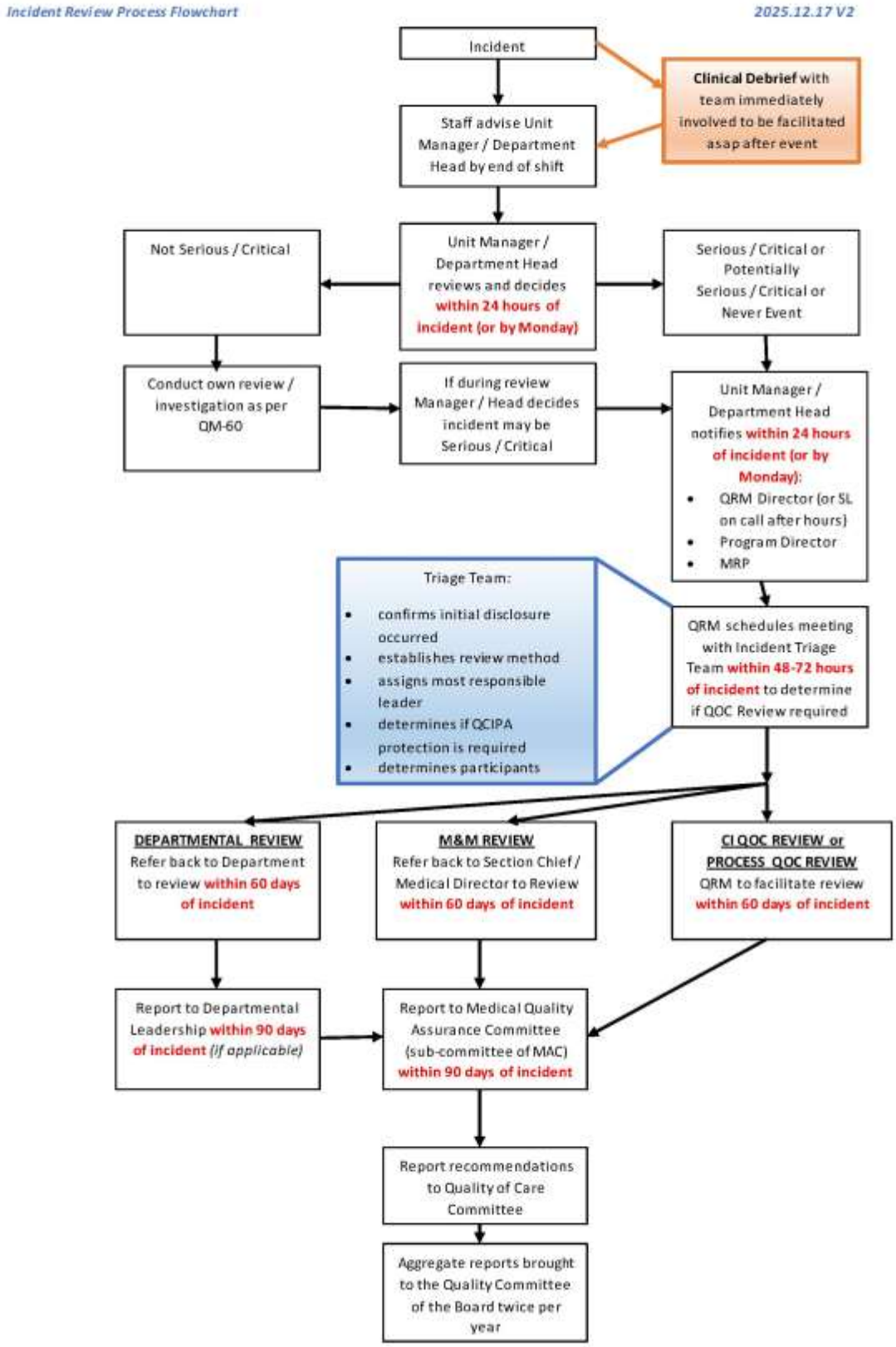
All discussions during the review will remain confidential. The Quality of Care Committee may disclose information pertaining to reviews (this may include recommendations and any other information) in accordance with the *Quality of Care Information Protection Act 2016*:

1. To key collaborators if the Committee considers that it is necessary for the purpose of improving or maintaining the quality of health care provided at the Hospital.
2. To a person or group of persons for the purpose of eliminating or reducing a significant risk of serious bodily harm.
3. To a Coroner for deaths in specified circumstances as they must be reported under the *Coroners' Act.*
4. To a Medical Officer of Health for certain communicable diseases as they must be reported under the *Health Protection and Promotion Act.*
5. To regulated colleges under the *Regulated Health Professions Act*, where an RHPA professional is terminated, resigns while under investigation or prior to being terminated, or has privileges restricted or revoked for reasons of professional misconduct, incompetence, or incapacity.
6. To the Patient / Substitute Decision Maker under the *Excellent Care for All Act*, where recommendations are implemented as a result of the review and should be communicated as soon as possible.

7. REFERENCES

Coroners' Act, 1990.
Excellent Care for All Act, 2009.
Health Protection and Promotion Act, 1991.
Hot Debriefing Guide, CICSL, BC Simulation Network and BC Emergency Medicine Network, 2020.
Hot Debrief Tool for All Codes / Incidents, Sunnybrook Health Sciences Centre.
Ontario Hospital Association, Quality of Care Information Protection Act Toolkit, 2004.
Quality of Care Information Protection Act, 2016.
Regulated Health Professions Act, 1991.
Serious Safety Event Triage Call Document, Grand River Hospital.

APPENDIX A
Incident Review Process Flowchart



APPENDIX B
Clinical Debriefing Guide

HOT DEBRIEFING GUIDE

This guide provides a standardized approach to post-event clinical debriefing.
These conversations are to be facilitated as soon as possible after an event with a target duration of 10 to 15 minutes.
These conversations are not to assess or evaluate personal performance and they do not replace other processes associated with critical events such as PSLS reporting, accessing employee assistance programs, or formal critical incident stress debriefings.

"Thank you for taking the time to gather and discuss this event.
Can I ask someone to assist with note-taking?
We believe this team is capable, has done their best, and is seeking to improve.
We have not gathered to assess or evaluate personal performance.
For this debriefing, we will use the STOP format."

S	T	O	P
Summarize The Case	Things That Went Well	Opportunities To Improve	Points Of Action

"Before we end this debriefing if anyone has any last remarks please share them.
As appropriate and with respect and confidentiality, these findings will be shared with our leadership team.
We will follow up on these items.
Thank you again for joining us. Please continue to take care of yourselves and each other.
Thank you for the work that you do."

Created by CICSL and members of BC Simulation Network and BC Emergency Medicine Network.
Available for download at:

HOT DEBRIEFING GUIDE

**Recent literature supports performance-focused post event clinical debriefings facilitated by healthcare professionals familiar with established debriefing processes.
Like other aspects in health care, bringing hot debriefing to clinical settings invites careful implementation considerations.**

Considerations for Introduction :

- Consider introducing this guide in advance of initial debriefings.
- Orientate your debriefers and your teams.
- Appreciate the impact of local culture and psychological safety.

Considerations for During:

- Affirm that participation is voluntary and not compulsory.
- Embrace a growth mindset, and a commitment to improvement.
- Learn from success and minimize hindsight bias.

Considerations for After:

- Assign findings to individuals for meaningful clinical improvement.
- Provide debriefers with ways to improve their facilitation skills.
- Provide local resources for those who may benefit from further psychological support.

With acknowledgement and thanks to:
Rose S, Cheng A. Charge nurse facilitated clinical debriefing in the emergency department. CJEM. 2018 Sep;20(5):781–5.
Walker C.et al. STOP5: a hot debrief model for resuscitation cases in the emergency department. Clin Exp Emerg Med (2020) 7(4):259-266.
Coggins et al. Interdisciplinary clinical debriefing in the emergency department: an observational study of learning topics and outcomes. BMC Emergency Medicine (2020) 20:79.
Coggins et al. Twelve tips for facilitating and implementing clinical debriefing programmes. Medical Teacher (2020) Published online.
Heart and Stroke Foundation of Canada 2020 Guidelines. Circulation. Vo. 142 (16): S599-600.

For feedback contact CICSL@viha.ca

https://www.vch.ca/en/media/17471

APPENDIX C
Clinical Debrief Tool

Instructions for leading a clinical debrief (~15 minutes):	Thunder Bay Regional Health Sciences Centre
1. Find a quiet space to gather the staff immediately involved in the incident. Thank everyone for participating and tell them the purpose of the debrief is for safety of everyone and quality improvement – it is not to find fault or blame. If staff must leave to attend to urgent needs, they may do so but their input is valuable and appreciated. 2. Assign a note taker to complete this form and submit completed form to Unit Manager / Department Head following the debrief.	

Clinical Debrief Tool for Critical Incidents / Codes

Date and Time of Incident: _____ Date and Time of Debrief: _____

Brief two-line summary of event *(details to be entered in ILS patient safety incident report)*:

Debrief Leader: _____

Participants Attending Debrief:
□ Manager/Supervisor □ Department Head □ Other(s): _____

Reflection / Outcome of Event
What went well?
What could be improved?
Questions/Learning Points?

If required, attach additional pages*

Patient / Family Perspective:

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Clinical Debrief Tool for Critical Incidents / Codes

Next Steps / Action Plan: Submit the report to the Manager / Department Head for record keeping and/or to support facilitation of next steps (e.g. departmental quality improvement initiative, education, consultation with Emergency Preparedness, Risk Management, Security, Human Resources, Occupational Health & Safety, etc.)

	Recommendation	Who will lead?	Complete by
#1			
#2			
#3			
#4			

If required, attach additional pages

Person responsible for ILS patient safety report *(one per incident)*:		***Please submit ILS report(s) immediately following debrief if not already done.***
OHS report(s) required? *(one per employee)*:		
Are emotional supports requested?:	□ Yes – Manager to arrange with assistance of OHS.	

Clinical Debriefs (aka "Hot Debriefs") are held following a critical incident or code to summarize the case, determine what went well and opportunities for improvement, and highlight where actions are required. They should occur within minutes to hours of the event, while emotions, reactions and impressions are still "hot".

Resource: https://www.vch.ca/en/media/17471

Modified from a Debrief Checklist created by Sunnybrook Health Sciences Centre *2025-12-17 V3*

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APPENDIX D
Clinical Incident Triage Log

Critical Incident Triage Log

Thunder Bay Regional Health Sciences Centre

Incident Date/Time:		**Meeting Date:**	
ILS Report #:		**Reported Severity:**	
Area/Program:		**Potential Harm Level:**	

Attendees *(check all in attendance)*
Quality & Risk Management:
□ VP □ Director □ Manager □ Patient Safety Lead □ Risk Management Lead
□ Chief Nursing Executive □ Chief of Staff □ MRP □ Chief of Department

□ Program Manager □ Program Director □ Other(s): _____

1. The purpose of the call is to discuss what we know about a recently flagged incident thus far and determine whether it is a potential critical incident or never event and decide upon next steps.
   As a reminder: *(read definitions)*
   Critical Incident: *Any unintended event that occurs when a patient receives treatment in a 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 from a known risk inherent to providing treatment.*
   Never Event: *Patient safety incidents that result in serious patient harm or death, and are preventable using organizational checks and balances that should be in place.*
   Also, please remember that everything discussed in this meeting is confidential and is for the purposes of improving quality of care.

2. Brief Summary of Case:

3. **Questions to consider:**

   Was it a critical incident?
   Was there a deviation from generally accepted performance standards?

   Did the deviation reach the patient? (If no, it was a Near Miss.)

   Did the deviation cause moderate to severe harm or death?

   Was it a known complication?
   Was the procedure/treatment/test appropriate or warranted for the patient?
   Was the complication a known risk and was the standard of care employed to mitigate risk?
   Was the complication identified in a timely manner?
   Was the complication treated according to the standard of care and in a timely manner?
   If the answer to each and every question is 'yes', the outcome should be classified as a known complication.
   If the answer to any question is 'no', the event should be considered a safety incident.

4. **Immediate actions required:**

Modified from a Serious Safety Event Triage Call document created by Grand River Hospital *2025.12.17 V3*
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5. **Initial disclosure has occurred?:** □ No □ Yes → Date: _____ By: _____

6. **Staff & Physician Supports required?:** □ No □ Yes: _____

7. **Next Steps:**
   a. Classification of Event: □ Critical Incident □ Never event □ Practice Review □ Known Complication
      □ Reportable Event → □ ADR □ MDI □ Other?: _____
   b. Level of Harm: □ Moderate □ Severe □ Death
   c. QOC Review required? □ No
      □ Yes → Type: □ Departmental → Quality Council / Committee Lead: _____
      □ M&M → Physician Lead: _____
      □ Critical Incident □ Process → QRM: _____
      Review to be completed within 60 days of incident, by *(date)*: _____
      QCIPA protected?: □ Yes □ No
   d. Further disclosures to be completed by: _____
   e. Staff & Physician Supports arranged by: _____

Additional Notes: