COLLABORATION

FAMILY

STRATEGIC PLAN

COMMITMENT

INDICATORS

COMMITMENT

ASSESS

## OBJECTIVES

This toolkit is intended to:

- Support boards to understand and integrate core governance functions related to quality and patient safety;

- Provide relevant information to boards regarding approaches for incorporating a focus on quality and patient safety;

- Identify and apply relevant and appropriate tools for creating and sustaining an effective board quality and patient safety plan; and,

- Enable board members' understanding of how a culture of quality and patient safety within an organization can be led, supported and sustained by the board.

## BACKGROUND

In the past decade the healthcare climate has embraced the imperative to improve quality and patient safety. This was first identified with studies showing pervasive quality and safety problems across health systems of developed countries. In Canada, 7.5% of patients admitted to acute care hospitals in 2000 experienced one or more adverse event, 36.9% of which were highly preventable (Baker et al. 2004). Researchers estimate that adverse events are responsible for the death of 5,000 to 10,000 Canadians each year (Wong 2004). Healthcare organizations have used a number of strategies to improve the safety of care within their organizations; however, in order for these strategies to be sustained, organization-wide commitment is required. Embedding principles of quality and safety into the culture and daily practices of each individual within a healthcare organization remains a formidable challenge and lengthy journey. The role of various groups, such as management, physicians and clinicians within this journey, has been studied and articulated, however the role of boards has been traditionally neglected. This, however, is changing as boards have been recognized as having a critical role in safety and quality improvement. Board members, traditionally coming from business, legal or government sectors tend to feel a lack of familiarity around the clinical aspects of quality and patient safety, and may experience apprehension around their contribution to quality and safety efforts at their organization.

This toolkit aims to provide resources to guide board members on their quality and safety journey, both as individuals learning to promote and understand quality and patient safety issues, and as members of a governance body supporting the delivery of high quality healthcare. Board leadership is a critical aspect of an organizations' journey to improve the quality and safety of care.

Governing boards of healthcare organizations are legally responsible for the performance of their organizations. To achieve their governing responsibilities in regards to quality and safety, boards can perform various functions: develop a vision around quality and safety improvement for their organization; define clear and set realistic goals; access, interpret and
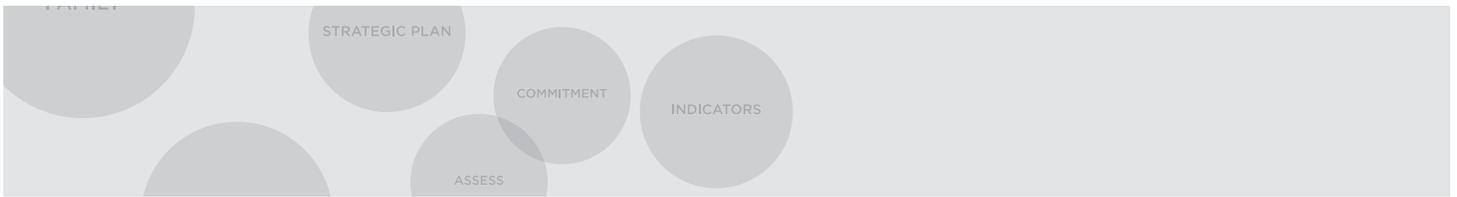
use valid and appropriate information; monitor performance relevant to these goals; and support initiatives to develop capabilities and foster a culture of quality and safety within the organization. However, these responsibilities are assumed in different degrees, there is variation in the structures and processes of healthcare governance with limited information on the effectiveness of different structures.

Recent developments in the Canadian healthcare landscape have also emphasized the importance of good governance in healthcare. There is growing evidence of problems in the general level of quality and safety of care across healthcare organizations including the findings of the Canadian Adverse Events Study as well as reports from organizations such as the Canadian Institute for Health Information (CIHI) and various provincial health quality councils which have further helped to advance our understanding of these issues. In response to this evidence and a need for greater transparency there have been significant improvements in the availability and quality of information about such issues at the level of individual hospitals and other healthcare delivery services and systems. This information has clearly demonstrated wide variations in performance between healthcare organizations. Finally, there is a growing effort to establish explicit accountabilities and to use these performance measures to hold CEOs and boards responsible for performance on quality and safety measures (in addition to financial performance). Greater demands for accountability and performance measurement have led to several enhancements to Accreditation Canada's accreditation program standards which focus on strengthening governance and clarifying the role of the board for quality and patient safety.

As a result of these drivers there is growing interest in understanding the strategies, tactics and tools through which boards can establish quality and safety goals and stimulate improvement in healthcare organizations, specifically in the Canadian context. In response to these needs, the Canadian Patient Safety Institute (CPSI) and the Canadian Health Services Research Foundation (CHSRF) partnered to commission a team of researchers to investigate governance for quality and safety in healthcare organizations. In 2008, the research team, lead by Dr. G. Ross Baker, synthesized the available scientific evidence from the literature on current structures, processes, strategies and tools used by healthcare boards in setting goals, monitoring improvements and achieving results for quality of care and patient safety. The researchers consulted with many healthcare leaders and board members to better understand the knowledge, skills and current practices of healthcare boards in hospitals and health systems across the country and internationally to prepare the report "*Effective Governance for Quality and Patient Safety in Canadian Healthcare Organizations*". The team also conducted case studies of four organizations whose boards have undertaken a quality and safety journey. The tools used by these organizations, and their stories, are woven through this toolkit to provide context, evidence and examples of how healthcare boards can exercise good governance for quality and safety.