



## WHAT IS QUALITY AND PATIENT SAFETY?

Accreditation Canada defines **quality** as “*the degree of excellence; the extent to which an organization meets clients needs and exceeds their expectations*”. Key attributes of high quality healthcare systems, as defined by the Institute of Medicine (U.S.) include safety, timeliness, effectiveness, efficiency, equity and patient centeredness. The Health Council of Canada Annual Report (2006) entitled *Clearing the Road to Quality* found that patient safety, information management, quality councils and performance reporting are four key strategies to improve the quality of healthcare.

The Canadian Patient Safety Dictionary (2003) defines **patient safety** as “*the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes*”. International efforts are underway to standardized taxonomy of key patient safety concepts share learning across health systems; thus, the World Health Organization’s (WHO) International Classification for Patient Safety defines **patient safety** as, “*the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment*”. Patient safety is often considered a component of quality, thus, practices to improve patient safety improve the overall quality of care.

The terms *patient, client, resident, service user* or *consumer* are often used interchangeably in healthcare. It is acknowledged that some terms may not be appropriate or preferred when referring to individuals who access healthcare services; depending on the care setting or sector, or the geographic region of Canada. For clarity and consistency, the term ‘**patient**’ is used throughout the Effective Governance for Quality and Patient Safety Toolkit.

## WHERE DOES GOVERNANCE FIT IN?

Pomey et al. (2008) conducted a literature review around the role of the board in quality and safety and how board policies and actions can impact quality and safety. Denis et al. (2005) defined the function of governance as: setting a vision, providing resourcing, information and skills development, relationship management, control and monitoring.

### 1. Vision

- » The board can place the values of quality and safety at the core of an organizational vision.
- » Boards can support the alignment of strategic and operational goals with quality and safety through vision and/or mission statements, and broad implementation strategies.



## 2. Resourcing and skills development

- » Board composition can ensure that there are individuals on the board who have expertise and knowledge to understand and promote quality and safety issues. Agenda setting at the board level will ensure that quality and safety is addressed at the board level and dealt with in a consistent approach.

## 3. Relationship management

- » The board has an indirect influence on processes that influence care delivery; however the quality of the relationship that the board develops with clinicians and the senior executive and management team is important in building trust and collaboration required to manage quality and patient safety.

## 4. Control and monitoring

- » The boards' role in continuous monitoring of performance and improvement with solid, clear indicators is a key element in a governance approach to quality and safety.