QUALITY AND PATIENT SAFETY: UNDERSTANDING THE ROLE OF THE BOARD
A MESSAGE FROM THE OHA

The Ontario Hospital Association (OHA) recognizes the governance implications to advancing quality and patient safety in hospitals. Therefore, we are pleased to provide our members with this policy document outlining the board’s role and responsibilities for improving quality of care in their institutions.

Quality and Patient Safety: Understanding the Role of the Board provides guidance to hospital boards dedicated to leading their institution’s quality agenda. Practical advice surrounding the board’s legislative duties, an introduction to the patient safety landscape in Ontario, and insight into how effective boards drive the quality agenda are all captured in this document. The OHA supports boards that embrace their role in advancing patient safety initiatives, and will continue to provide governance resources aimed at significant and sustainable quality improvement.

Enhancing quality of care and patient safety is a challenge for hospitals of all sizes and types. The OHA appreciates how active and driven hospital boards can enhance patient safety in their institutions. We hope you find this to be a valuable resource as your hospital aims to deliver the best quality of care possible to your patients.
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Quality of care and patient safety have always been of paramount concern for hospitals, indeed for medicine in general. Medical historians, in fact, are fond of quoting Hippocrates’ admonition to “First, do no harm,” explaining that he must have noted the potential to do harm when offering treatments of the day. The quality and safety issue can be best understood by examining its past, looking at the public’s perspective of the problem and by understanding the current patient safety landscape.

**ORIGINS OF THE QUALITY AND SAFETY PROBLEM**

Until the twentieth century, hospitals were often the refuge of the poor and those admitted could see their condition worsen with disease and pestilence acquired from the very institution where they had sought treatment.

The modern hospital, by contrast, is a sophisticated center for technically advanced diagnosis and treatment where patients can expect excellent prospects for marked improvement following admission. So why is there such a major focus on improving quality and safety?

In 1984, a group of Harvard investigators studied risk management in the New York hospital system and uncovered a level of serious errors that attracted international attention. In their report in the *New England Journal of Medicine* (NEJM 324: 370-377, 1991), they reported previously undetected hospital error rates that could be extrapolated to represent 98,000 deaths per year across the United States. They also speculated that 500,000 U.S. patients a year could be suffering from medication errors alone.

Ten years later, Betsy Lehman, a columnist for *The Boston Globe*, died from an accidental overdose of a powerful cancer chemotherapy agent. She was a patient at the famous Dana-Farber Cancer Institute, and the subsequent investigation lead to dramatic changes at the Institute, which received widespread publicity.

High profile incidents such as these, as well as further studies and reports prompted the prestigious Institute of Medicine of the U.S. National Academy of Sciences to form a Committee on Quality of Health Care in America. The Committee published its findings in a now iconic book entitled, *To Err Is Human: Building a Safer Health System*. This was followed soon after by a second key publication, *Crossing the Quality Chasm: A New Health System for the 21st Century*. These well-researched and thoughtful books have essentially become instruction manuals for change and improvement in quality and safety in hospitals.

As these reports emerged in the U.S., we had a tendency here in Canada to think it was less of a problem because of our publicly-funded, single-payer system. It was thought likely that we would have a higher and more uniform standard of quality and safety. But in 1999, a study was launched that examined Canadian hospitals using criteria similar to the U.S. studies.

Published in 2004 in the Canadian Medical Association Journal, it showed that our inadvertent error rate was 7.5% -- just as high as in U.S. studies.

Indeed, vigorous attention to hospital quality and safety was warranted in Canada as well.

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THE PUBLIC PERSPECTIVE ON QUALITY OF CARE AND PATIENT SAFETY

The quality of care in our hospitals and the safety of our patients have attracted intense public scrutiny in Ontario and across Canada. Current coverage of these issues by the media has been no less intense in our jurisdictions than it has been in the U.S.

When the Canadian Institute of Health Information released statistics on mortality rates in hospitals in November 2007, a major national press conference was held to address all the requests for media coverage. Newspapers, radio and television reporters covered the event as a front-page lead item for days afterwards.

THE CURRENT PATIENT SAFETY LANDSCAPE

The issues of quality and safety in hospitals are of sufficient enough concern to warrant the existence of a vast array of experts and groups seeking solutions.

As mentioned earlier, it was an academic approach that first brought the current problems to light. University-based research and education continues to play a vital role in identifying problems and proposing and testing solutions, with academic journals devoted exclusively to this topic. Leadership and expertise has come from public health departments, medical and nursing schools, as well as business schools.

Medical and surgical specialty and subspecialty associations and societies have developed standards for safe and effective care that have helped with education, as well as with the implementation of quality and safety measures.

Professional organizations (e.g., Ontario Medical Association, Ontario Nurses Association) and regulatory colleges (e.g., College of Physicians and Surgeons of Ontario, College of Nurses of Ontario) have also played an important role in developing standards and publishing reports. Indeed, hospitals themselves have led in the development of processes and measurements that are designed to improve quality and safety. Some hospitals are acknowledged as pioneers and leaders in this effort, and have been designated ‘high performing hospitals’ by the groups who study them. A frequently cited example in the U.S. is the Veterans Administration, which is credited with changing the quality and safety in its system from low to high performing.

In Canada, the Saskatchewan hospital system offers a model for implementing improvements on a province-wide basis, and the Calgary Health Region’s Quality, Safety & Health Information portfolio has developed leading practices through its successful quality and safety management framework.

A number of existing organizations have formed groups to specifically foster quality and safety in hospitals. The Institute for Healthcare Improvement in the U.S. was one of the first, with similar organizations developed in the U.K., Australia and elsewhere.

In Canada, the Canadian Patient Safety Institute provides focused leadership, as does the organization Safer Health Care Now! and Accreditation Canada (formerly the Canadian Council on Health Services Accreditation), which performs a cycle of reviews for all hospitals, and has introduced a large number of required organizational practices in the quality and safety area.

In Ontario, the Ministry of Health and Long-Term Care has appointed an arm’s length monitoring group, the Ontario Health Quality Council that reports annually on the topic, and the success of Cancer Care Ontario in introducing quality and safety measures province wide is as noteworthy as it is laudable.

Through these initiatives and organizations, the patient safety movement is certainly gaining momentum.
UNDERSTANDING THE ROLE AND DUTIES OF THE BOARD

The role of the board is to govern and manage the affairs of the hospital. A board is responsible for ultimate oversight and decision-making, subject only to those very limited matters reserved to members by the Corporations Act, the Letters Patent or the hospital’s by-laws. However, in complex organizations such as hospitals, the board delegates the day-to-day management to the CEO, who in turn delegates to management and staff. Accordingly, in addition to its direct role, the board will also oversee management decisions and performance.

Within the board’s broad governance role, there are a number of specific roles that are performed by the board, as prescribed by statute, including electing or appointing board officers, approving financial statements, appointing the chief of staff and the chiefs of departments and appointing, revoking or suspending physicians, dentists, midwives and extended class nurses.

Hospitals also have a number of responsibilities that come from sources outside of legislation, such as policies, agreements, and the common law. The board’s ultimate oversight role includes ensuring that these further responsibilities are fulfilled.

Apart from these specified duties, a hospital board defines its own role. In other words, the board writes its own job description.

Apart from matters reserved to members, there is nothing the board is legally prohibited from doing. So rather than ask, “What can we do?” the real question it should ask is, “What should we do?”

If it is to specifically focus on quality and patient safety, a board should ask itself, “What are our obligations to the organization, and where as a board should we be spending our time and energy to ensure that we are meeting these obligations?”

As with every board decision, it must ensure that whatever it decides, it must be in the best interests of the hospital.

Guiding such decisions is the fiduciary standard. For an individual director, that means asking, “Based on my skill and judgment, what do I, in good faith, believe our board should be doing to ensure organizational quality and success and sustainability of the hospital?”

The answer to that question will require a board to exercise a direct role in areas that impact the organization’s success and sustainability, including quality and patient safety.

WHAT ARE THE BOARD’S LEGISLATED RESPONSIBILITIES FOR QUALITY?

There are no express requirements in the legislation governing Ontario public hospitals regarding the board’s role for quality. In particular, there is no requirement for a board to establish a Quality Committee.

However, as a consideration of receiving wait time funding for the period April 2007 to March 2008, for example, hospitals were required to establish a Quality Committee with a specific mandate to review the Hospital Standardized Mortality Rate (HSMR) with management on a quarterly basis, and to review the number of patients reassessed as a result of waiting longer than the Priority IV target time frame. In addition, for the first time in Canada, HSMR data was publicly released in November 2007 by the Canadian Institute for Health Information.

There are, however, references in the legislation to quality-related issues, some of which impose duties on hospital boards, and some of which impose duties on
the hospital corporation. Given the board’s ultimate oversight role, it bears the final responsibility of ensuring that the hospital’s duties are fulfilled.

There are a number of pieces of legislation that relate to the board’s role in ensuring quality and safety, and that are worthy of note. These include the following:

**Public Hospitals Act**

The *Public Hospitals Act* establishes a structure for supervising the quality of care provided by medical, dental, midwifery and extended class nursing staff. The Act requires the board of a public hospital to establish a Medical Advisory Committee comprised of the president, vice president, secretary of the medical staff association, chief of staff and the chief of the dental staff and other such members of the medical staff as are elected or appointed in accordance with the by-laws of the hospital. The board is also responsible for appointing the chief of staff (or where the hospital’s by-laws do not provide for the chief of staff, the chair of the Medical Advisory Committee).

The Medical Advisory Committee is responsible, as described in the Act, to make recommendations to the board concerning the quality of care provided in the hospital by the medical, dental and midwifery staff and by the extended class nursing staff with respect to the ordering of diagnostic procedures.

It also makes recommendations to the board with respect to clinical staff appointments and re-appointments, privileges, medical staff by-laws and clinical and general rules respecting medical, dental and midwifery and extended class nursing staff.

Significantly, the Medical Advisory Committee has a duty under the Act to supervise the practice of medicine, dentistry and midwifery in the hospital and supervise the ordering of diagnostic procedures by members of the extended class nursing staff. As a result of the role of the Medical Advisory Committee, as prescribed by the *Public Hospitals Act* and its regulations, accountability for quality of care in a hospital context is sometimes described as a bifurcated or two pillar model (illustrated below).

The following are examples of specific requirements under the *Public Hospitals Act* and regulations:

**Critical Incident Reporting**

As of July 1st, 2008, hospital boards are responsible for ensuring that their administrators (CEOs) comply with new critical incident reporting provisions in the *Public Hospitals Act*. Hospitals will be required to disclose to patients affected by critical incidents:

(a) The material facts of what occurred with respect to the critical incident;
(b) The consequences for the patient involved in the critical incident; and,
(c) The actions taken, and recommended to be taken, to address the consequences to the patient involved in the critical incident.
Hospital boards will also be responsible for ensuring that the hospital administrator establishes a system for disclosing to patients any systemic steps the hospital takes to avoid or reduce the risk of further similar critical incidents.

**Occupational Health And Safety**

Pursuant to the Hospital Management Regulation made under the *Public Hospitals Act*, hospitals must establish and provide for the operation of an occupational health and safety program. The program must include procedures with respect to:

(a) A safe and healthy work environment;
(b) The safe use of substances, equipment and medical devices;
(c) Safe and healthy work practices;
(d) The prevention of accidents to persons on the premises; and,
(e) The elimination of undue risks and the minimizing of hazards inherent in the hospital environment.

**Health Surveillance**

As set out in the Hospital Management Regulation, hospitals must also establish and provide for the operation of a health surveillance program (including a communicable disease surveillance program) that will apply to everyone working in the hospital.

**Quality of Care Information Protection Act**

The *Quality of Care Information Protection Act* (QCIPA) restricts the disclosure of information that is prepared by or for a quality of care committee (QCC), a special committee created according to this legislation and governed by it. It is distinct from any other Quality Committee of the hospital board.

The basic principle is that quality of care information from a QCC is privileged and may not be used in any proceeding. However, the legislation does permit this information to be disclosed to management, which includes the board, if it is “appropriate to do so for the purpose of improving or maintaining the quality of health care provided in or by the facility.”

Since the goal of this legislation is to protect the disclosure of quality of care information, the QCIPA does not dictate what the board should or must do with the quality of care information it receives from a QCC. Nonetheless, the Act permits disclosure “to an agent or employee of the facility if the disclosure is necessary for the purposes of improving or maintaining the quality of health care provided in or by the facility.” Quality of care information may also be disclosed to anyone “if necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.”

**Commitment to the Future of Medicare Act, 2004**

Under this Act, Ontario hospitals are required to enter into Service Accountability Agreements with the Ministry of Health and Long-Term Care or their Local Health Integration Network. These Service Accountability Agreements may include performance goals and objectives respecting service quality.

**Local Health System Integration Act, 2006**

Under this legislation, a Local Health Integration Network may require a hospital, among other things, to provide a service to a particular “level, quantity, or extent.” However, the legislation does not mention the quality of services provided by hospitals.
Summary of Legislative Responsibilities

It is critical that the board inform itself of its direct and indirect statutory duties, and ensure that processes are in place to perform these duties.

Although compliance with many of these obligations may be delegated to senior management, the board is ultimately responsible for decision-making and oversight.

The general principles outlined below with respect to the board performing its fiduciary duties to the hospital are also of assistance in ensuring compliance with legislative duties.

WHAT ARE THE COMMON LAW DUTIES OF THE BOARD?

The general rule for corporate accountability is that a corporation is accountable for corporate obligations. A corporation is also liable for the actions of its employees through the principle of vicarious liability.

In a hospital context, the corporation is not exclusively accountable for common law obligations related to quality of care. The hospital is accountable for “hospital services” and physicians are accountable for “physician services.” The courts have recognized that a hospital does not have a “non-delegable duty of care,” which would impose liability on the hospital for negligent care provided by physicians.

Generally speaking, hospitals owe the public three types of duties:

1. They are responsible for the conduct of their employees;
2. They are responsible for the selection of their staff (physicians, dentists, midwives and extended class nurses); and,
3. They are responsible for patient safety and protection, and the provision and maintenance of hospital services, which includes equipment and systems, protocols and processes as well as the safe operation of premises and facilities.

Employee Conduct

Hospitals are not responsible for the negligence of physicians to whom they have granted privileges. The seminal case of Yepremian v. Scarborough General Hospital affirmed that, in Canada, physicians are independent contractors who are directly liable to their patients. In Yepremian, the Ontario Court of Appeal specifically held:

The practice of medicine and the operation of hospitals have been conducted on the understanding and belief that the law established and supported the independence of the medical profession, in the manner in which they practised, free from the control and direction of hospital boards […]

However, hospitals are responsible for the negligence of their employees, such as nurses and laboratory technologists. Boards must therefore ensure that policies and procedures are developed and implemented to ensure that employees meet the reasonable standard of care expected of their profession.

5 Ibid.
6 Ibid at 554 [emphasis added].
Staff Selection

Hospitals hold themselves out as places where members of the public can receive health care from competent professionals. Hospitals therefore have a duty at common law to ensure that they have selected their staff with care. This duty has been expressed as a “non-delegable duty to review and monitor qualifications and competence”. This means that, although the Medical Advisory Committee may make recommendations with respect to physician privileges, the board must exercise its ultimate duty to select staff with care.

This duty of care with respect to staff selection also applies to a hospital’s employees. It extends as well to physicians who, although not usually employees of the hospital, provide services to hospital patients. The nature of this duty was set out in *Yepremian*, where the Ontario Court of Appeal held:

>[A] member of the public […] is entitled to expect that the hospital has picked its medical staff with great care, has checked out the credentials of every applicant, has caused the existing staff to make a recommendation in every individual case, makes no appointment for longer than one year at a time, and reviews the performance of its staff at regular intervals.

A hospital fulfills this common law duty of care by selecting physicians for appointment or re-appointment according to the procedure in the *Public Hospitals Act* and the criteria set out in the hospital’s own by-laws.

Generally speaking, the board performs its role with respect to the quality of medical, dental, midwifery and extended class nursing staff selection by:

- Approving by-laws that establish criteria and create the process for appointments, reappointments, suspensions and revocations;
- Appointing senior officers and medical staff leaders (CEO, chief of staff/chair of MAC, department leaders);
- Establishing the Medical Advisory Committee;
- Making decisions on the strategic direction of the hospital that will impact human (medical) resource plans; and,
- Exercising oversight to ensure the established process is followed.

Patient Safety and Protection

The *Canadian Charter of Rights and Freedoms* does not confer a free-standing right to healthcare. However, where a hospital provides healthcare it must do so at a standard that may reasonably be expected of the community it serves. This reasonable community standard applies to the obligation of the hospital to provide competent personnel, adequate facilities and equipment, as well as protocols and processes.

Hospitals are responsible for providing a “safe system” and will be directly liable to patients if they do not ensure the proper operation of the hospital system. They are also responsible for related functions, such as inadequate or improperly maintained equipment.

It is ultimately the board’s responsibility to ensure that the quality of patient services provided by their hospital is monitored, and to ensure that it meets the standard that can be reasonably expected of the community it serves. This will involve difficult decisions with respect to resource allocation.

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8 *Yepremian* at 514 [emphasis added].
If the hospital determines that it will provide a service to the community, it must meet a reasonable standard in providing the service. On the other hand, if the hospital determines that it does not have sufficient resources to provide a service at the level that may reasonably be expected by the community, there is no duty to provide the service, and therefore the hospital should discontinue the service.

A board will necessarily rely on management with respect to these determinations, but it retains ultimate oversight and responsibility.

THE IMPACT OF OTHER ACCOUNTABILITIES AND RESPONSIBILITIES

Strategic Planning and Mission, Vision and Values

Specific decisions that impact the quality of services are made within the context of the hospital’s mission, vision, values and strategic direction; the board participates in their formulation and adoption. The board is also responsible for ensuring that annual plans, including its annual work plan, are consistent with the hospital’s strategic directions.

In order to discharge these duties, the board should receive regular briefing or progress reports on implementation of strategic directions and initiatives, and should conduct an annual review of the strategic plan as part of a regular annual planning cycle.

Financial Condition

The board is responsible for stewardship of financial resources including ensuring the availability of, and overseeing allocation of, financial resources. Most importantly, the board ensures that financial decisions, particularly resource allocation decisions, are consistent with strategic directions and accountabilities.

With respect to quality, the board must understand the impact that resource allocation decisions will have on the attainment of quality indicators.

Executive Performance

Part of the board’s role is to oversee the hospital’s senior management. This includes the selection, supervision, and succession planning for the CEO and chief of staff. These duties are key elements of the hospital’s performance with respect to quality of care. The board recruits and supervises the CEO and Chief of Staff by:

- Developing and approving job descriptions;
- Undertaking recruitment and selection processes;
- Reviewing and approving annual performance goals;
- Reviewing performance and determining compensation;
- Ensuring that succession planning is in place for the CEO, Chief of Staff and senior management;
- Overseeing the CEO’s supervision of senior management as part of the CEO’s annual review; and,
- Developing, implementing and maintaining a process for the selection of department chiefs and other medical leadership positions as required under the Hospital’s by-laws or the Public Hospitals Act.
External Relationships: Stakeholder Communication and Accountability

Hospital stakeholders are broadly defined and include the community served, staff, donors, government and other health providers. The quality of the hospital’s relationships with its stakeholders is a direct board responsibility, and the implications of this responsibility are significant.

The quality of stakeholder relations impacts the hospital’s reputation, which in turn impacts morale, patient and community confidence; donor confidence, and staff recruitment and retention, all factors that in turn impact the quality of services.

In order to perform this duty, the board must:

- Identify the hospital’s stakeholders and understand stakeholder accountability;
- Ensure communication with stakeholders in a manner consistent with the hospital’s accountability to stakeholders; and,
- Perform advocacy on behalf of the hospital with stakeholders where required in support of the mission, vision and values and strategic directions of the hospital.

The board must also oversee the hospital’s performance of its obligation under the Local Health System Integration Act, 2006 to engage the community when establishing plans and setting priorities.

Accreditation

Although accreditation of Ontario public hospitals is not required by law, approximately 95% of Ontario hospitals undergo accreditation by Accreditation Canada.

Accreditation Canada develops national standards with respect to a number of areas, including patient care and governance.

The accreditation process involves three steps: self-assessment, where hospitals rate their compliance with the national standards; peer review, where Accreditation Canada surveyors attend at the hospital to review compliance; and the accreditation report, provided to the hospital on a confidential basis, which summarizes Accreditation Canada's findings. The accreditation report and the recommendations contained within it are tools that guide health care organizations in their efforts to improve quality.

Accreditation Canada’s newly updated accreditation standards include eight required dimensions for quality:

1. **Population Focus** (working with communities to anticipate and meet needs);
2. **Accessibility** (providing timely and equitable services);
3. **Safety** (keeping people safe);
4. **Worklife** (supporting wellness in the work environment);
5. **Client-centred Services** (putting clients and families first);
6. **Continuity of Services** (experiencing coordinated and seamless services);
7. **Effectiveness** (doing the right thing to achieve the best possible results); and,
8. **Efficiency** (making the best use of resources).

In hospitals that undergo voluntary accreditation, it is the board’s ultimate responsibility to ensure that the particular markers set by Accreditation Canada to evaluate compliance with these dimensions are met. These dimensions are very broad and necessarily involve compliance with the statutory and common law duties of the hospital and the hospital board, which are described in this document.
Contractual Obligations

There seems to be an increasing interest within the Ministry to use contractual mechanisms to ensure board accountability for quality and safety. For example, in March of 2007, based in part on the advice submitted, the Ministry issued a letter to all hospitals receiving wait-times funding with a number of new requirements.

Among these were instructions for quality and safety, asking boards to ensure that they had a Quality Committee that reports regularly to the full board on the safety and quality of hospital care. It also asked that the Board Quality Committee review the Hospital Standardized Mortality Ratio with management on a quarterly basis, and review the number of patients waiting longer than the appropriate time frame for each service area.

The instructions also asked that the hospital work towards submitting data to Safer Health Care Now! regarding central line infections, surgical site infections and ventilator-associated pneumonia.

A similar condition was included in wait-times funding letters for March 2008, with an additional expectation that hospitals publicly report this information through their hospital web site by December 2008.

CREATING A CULTURE OF SAFETY

Improving the quality and safety of patient care, however, requires an organization-wide commitment to building and sustaining a culture of safety. In the patient safety literature, an organization with a true culture of safety is one where there is a constant and active awareness of the potential for things to go wrong, and where staff and the organization are able to acknowledge mistakes and learn from them to make system-wide improvements. The leadership of an organization is central to setting the values and beliefs of an organization’s culture. The board has a critical role to play in building a safety culture that is open and fair. The board needs to establish an environment where the whole organization learns from safety incidents and where staff are encouraged to report and proactively assess risks.

The value of a culture of safety, however, not only benefits the organization-at-large. It will also help health care organizations achieve improvements within their clinical governance agenda. According to the National Patient Safety Agency, “a key part of achieving good clinical governance is recognizing that it is not always possible to achieve the perfect outcome clinically and that lessons learned are an important and integral part of a continuous program for quality improvement.”

12 Ibid.
ENSURING QUALITY AND SAFETY WITH DUE DILIGENCE

The responsibility for advancing hospital patient safety is one that requires thoughtful leadership and oversight at the board level. As described in the earlier sections, to make truly significant contributions to their organization’s quality of care, a hospital board needs to become familiar with the issue of patient safety and familiarize itself with its various legal obligations. This will ensure that the board is actively engaged and able to make informed decisions in discharging its obligations.

In addition to the particular suggestions outlined above, there are a number of actions a board can take to ensure that it exercises appropriate collective due diligence in the performance of its roles and responsibilities with a view to ensuring quality.

Establish a Skilled and Qualified Board

A board should expressly assume responsibility for the quality of board succession and should adopt practices in board recruitment, nomination and election processes that will, to the maximum extent possible, ensure that the board recruits and retains candidates with the necessary skills, experience and qualities to contribute to the performance of the board’s roles. In particular, the board should consider recruitment of directors with expertise in quality, safety, and client satisfaction.

Ensure the Board is Knowledgeable

In the context of quality, each director must understand the following:

- The governance role of the board and the fiduciary duties that apply to individual directors;
- The areas of board responsibility for quality and the nature of the board’s role in each area;
- The legal framework in which the public hospital operates (both statutory and common law);
- The hospital’s operations; and,
- The role of management and the relationship between management and the board, including the board’s oversight responsibility for management.

In particular, the board must be educated with respect to its responsibilities for clinical quality, patient safety, and selection of staff. Further, the board must actively engage in discussions with management and identify appropriate indicators of organizational quality. It must also have a firm grasp on what these indicators mean, how they are tracked and what factors will influence or impede their attainment. (This is discussed more fully below.)

The board must also understand the implications that other board decisions will have, in particular resource allocation decisions, on the achievement of performance indicators.

Establish Structures and Processes to Support High-Performing Governance

In addition to the importance of recruiting a qualified board, there are three aspects of its own governance that can significantly impact the board’s contribution to quality:

Effective Use Of A Quality Committee

As described earlier, apart from wait-time funding agreements, there is no legal requirement for Ontario public hospitals to establish a Quality Committee. However, given the complexity of the issues in this area,

it is hard to imagine that a board could properly perform its role with respect to quality of patient care and services without relying on a Board Quality Committee.
A board that takes its responsibility for quality seriously will establish a board sub-committee to be responsible for quality issues on its behalf. The responsibilities that may be delegated to such a committee include: reviewing and recommending policies and standards, overseeing compliance with quality and safety related issues, including accreditation, and reviewing and making recommendations following adverse events.

It is important to reiterate that although the board may delegate such tasks to a Quality Committee, it remains ultimately responsible for oversight and decision-making with respect to these issues.

Although a Quality Committee may be called upon by the board to assist it in carrying out its responsibilities with respect to overseeing the quality of care and patient safety provided by the hospital, its role is separate from that of the Medical Advisory Committee.

As described in the Public Hospitals Act, the role of the Medical Advisory Committee includes making recommendations to the board with respect to appointing, revoking, suspending or refusing to reappoint a member of the medical, dental, midwifery or extended class nursing staff. It can also make recommendations to the board concerning the quality of care provided in the hospital by these professional groups and ultimately supervises their practice.

Although the Medical Advisory Committee’s recommendations in this respect may involve and be influenced by quality issues, and may involve liaising with the Quality Committee and the board, the specific functions of the Medical Advisory Committee remain distinct from the responsibilities delegated to the Quality Committee by the board.

Meeting Processes
The proper preparation and conduct of board meetings is a critical component of board performance. The board should review its meeting processes with a view to ensuring that these contribute to and aid the board in discharging its responsibility for quality.

Particular attention should be paid to timelines and meeting particulars, including the quality of committee reports, as well as the agenda location and time allotted for issues that impact on quality.

The board should occasionally analyze the amount of time spent in discussion on various topics with a view to assessing the relative impact of such matters on hospital success.

Board Leadership
The board chair plays a critical role in two areas that impact on the overall board performance. The chair sets the agenda for board meetings and is responsible for facilitating and moving forward the business of the board. Therefore, the board chair significantly influences the content and process of these meetings. Board chairs and board members need to understand the chair’s role. Boards need to ensure they have position descriptions for the role of the chair and recruit to their boards, individuals with the capacity for effective board leadership.

Identify and Manage Risks
The board must be knowledgeable about risks inherent in hospital operations and ensure that appropriate risk analysis is performed as part of its decision-making. In particular, the board:

- Oversees management’s risk management program;
- Ensures that appropriate programs and processes are in place to protect against risk; and,
- Is responsible for identifying unusual risks to the organization and ensuring that there are plans in place to prevent and manage such risks.
SELECTING AND MONITORING PERFORMANCE MEASURES

The single most important step the board can take to contribute to quality is to establish a process and a schedule for monitoring and assessing performance in areas of hospital operations that contribute to quality. Particular areas for measurement include safety and quality of patient care, and quality of hospital services.

There are three main roles for the board with respect to performance monitoring and assessment:

- Ensuring that management has identified appropriate measures of performance;
- Monitoring hospital and board performance against board approved performance standards and indicators; and,
- Ensuring that management has plans in place to address variances from performance standards indicators and the board oversees implementation of remediation plans.

For example, the board should have a high level of understanding of key safety and quality indicators such as HSMR. The board should understand what the hospital’s HSMR is and how the hospital plans to improve.

Further, the Strategic Balanced Scorecard developed by Sunnybrook Health Sciences Centre is an outstanding example of monitoring and tracking hospital performance against a board approved strategic plan.

Presented as an interactive, online tool, Sunnybrook’s scorecard allows board members, as well as hospital staff and the general public, to examine the hospital’s progress in eight strategic goals. Three of these goals are under the realm of Quality and Patient Care and they are each comprised of objectives that are measured and reported on annually.

The measures that the board uses, particularly in the areas of quality of patient care and hospital services, must meet the principles that apply to all reporting systems: performance objectives must be established, actual results reported, and an assessment provided as to whether corrective or remediation action is required.

If there is more than one remediation option, a risk or cost-benefit analysis must be provided for each option. Reports to the board must provide it with enough information to determine if corrective action is required. And if a board decision is required, sufficient information must be given to determine the best course of action.

The board must look to management to report on key areas, and management’s responsibility in this regard needs to be clearly understood. The board’s role is both oversight and judgment, in other words, the board reviews management’s reports and is entitled to rely on them, but is also required to exercise its independent judgment in evaluating the reports. That role requires the board, or a board committee on behalf of the board, to ask the Why, How and What If questions, such as:

- Why these measures?
- Why these targets or performance corridors?
- Why these assumptions?
• How do these indicators link to our strategic plan and our annual plan?
• How do we compare to our peers?
• How does not meeting one indicator impact others?
• How will certain assumptions impact results?
• What if the assumptions are not achieved or wrong?
• What if the target is not met?
• What if the recommended strategy does achieve results?

Boards need to employ reporting tools that provide a simple and clear indication of the hospital’s performance of specific indicators in different areas of hospital performance. Common areas for measurement of quality might include Patient Service (care, access, outcomes) and Organizational Health (staff recruitment and retention, safety and sick days). More and more, boards are turning to tools such as balanced scorecards or dashboards to illustrate performance measures. A balanced scorecard or dashboard provides a snapshot measure of the selected indicators in each area or quadrant of performance.

BE PREPARED TO REACT

A board must decide when and how to react when actual performance does not match planned performance.

Management is expected to take action to address remediation of performance issues and to report its actions to the board. Since it is unlikely to know what options are available, the board will necessarily rely on management with respect to remediation. However, under urgent or unusual circumstances, the board may have to take a more direct role in managing remediation plans. While it is entitled to rely on management, the board must remember that it is ultimately responsible for decision-making and oversight. Its reaction to the information it receives is its responsibility.

ENSURING THE QUALITY OF BOARD’S OWN PROCESSES AND SYSTEMS

Ongoing monitoring and supervision is a core component of board due diligence. Having created appropriate structures and processes and other systems to support its responsibility for quality, the board must continue to monitor and supervise those processes and its own governance systems. This includes periodically evaluating its recruitment processes, board composition and size, use of committees and their terms of reference, processes for appointment of the chair, and the board’s relationship with management.
PROMOTING OPENNESS AND ACCOUNTABILITY

Hospital boards should be aware that as the patient safety agenda evolves, so too will the expectations on accurate and timely public reporting from service providers. Particular to hospital boards, there is an increasing emphasis on board accountability, which includes public reporting of a number of measures.

MANDATING THE REPORTING OF KEY INDICATORS

In May 2008, the Minister announced that hospitals would be required to publicly report on the ‘superbugs’ MRSA, VRE and C. difficile. These ‘superbugs’ will need to be publicly reported over the coming year, on a staggered basis along with three Safer Healthcare Now! indicators (rates of ventilator-associated pneumonia, central line infections, and surgical site infections), as well as hand hygiene compliance rates. In addition, the Minister of Health and Long-Term Care announced that C. difficile would be declared a reportable disease.

FOCUSING ON THE QUALITY OF A BOARD’S GOVERNANCE

Boards of Trustees in Ontario hospitals are responsible for the quality and safety of patient care and should ensure that they are familiar with the issues and overall directions of this field. CEOs and their management teams should have an organizational structure and function that captures key quality and safety data from across the hospital.

Effective board governance creates the platform upon which the board performs its role for ensuring the quality, success and sustainability of the hospital. The board must begin with a focus on the quality of its own governance. However, as described throughout, there are a number of areas where the board has a particular role to play with respect to the quality of patient care and patient safety.

Using the tools we have outlined, the hospital board can effectively perform its fiduciary duties to the corporation with respect to quality of care and patient safety by meeting its various statutory and common law responsibilities and by ensuring that it is effectively overseeing management activities.
Hospital boards vary widely in size, composition, and in how members are appointed. But most boards have one thing in common: the majority of the members are typically not health care professionals. Rather than doctors and nurses, they tend to be community leaders with expertise in banking, politics, engineering, real estate…almost anything except the delivery of health care.

It is no surprise then that boards have historically focused most of their attention on hospital finances, facilities, and strategic plans—things they know something about—and left matters of quality and safety of care to the medical staff.

In the last 10 years, there has been a dramatic increase in public awareness of quality and safety problems in hospitals.

Stories of medication errors, hospital-acquired infections, wrong-site surgeries, and needless deaths have made headlines. Hospital performance reports on reliability of evidence-based medicine, safety, and mortality rates for various procedures have become widely available on the Internet.

The people who live in each hospital’s community, the ‘shareholders’ or ‘owners’ whom the board represents, are also putting pressure on the boards to make hospitals safer. And government leaders, the regulators to whom the board is ultimately accountable, are placing ever higher levels of regulatory and legal pressure on hospitals for improvement.

As a result of all these factors, hospital boards are learning that they cannot continue to simply delegate the responsibility for quality and safety to medical staff. Rather, the boards themselves must set more aggressive aims, review better data, ask harder questions, and establish higher levels of accountability for performance in clinical care.

In essence, the same high level of oversight boards have used to manage finance must now also be applied to quality and safety.

What follows is a guide of sorts designed to show how a board can more effectively oversee clinical quality and patient safety when members often do not know anything about the technical and professional issues in health care.
At its core, successful leadership of improvement requires the generation of a strong will to improve, good ideas for improvement, and an effective execution of those ideas.13

Because most members are not clinically trained, boards tend not to be primary sources of specific ideas on how clinical care might be improved. But boards do play a strong role in the will to improve and the execution of ideas, as well as in another function essential for the long-term transformation of hospitals, constancy of purpose.

Will As the highest authority in a hospital, governing boards play a vital role in the generation of the will to improve. When organizations are weak-willed, and lack the ‘spine’ to push, through fear of change and other barriers to improvement, the failure to improve can be traced back to the board, and specifically, to the signals that may have been sent (in many instances, unwittingly) communicating that, in effect, the board is not really serious about making this change.

When a board adopts good policies such as mandatory safety timeouts before all surgical and other interventional procedures, for example, but then hesitates to act when members learn that the policies are being routinely ignored by some staff, it is signaling an absence of will to improve safety.

Execution While it is not the responsibility of board members to go out into their hospitals and make changes happen, it is the board’s responsibility to expect the changes to happen, and to hold executive teams to account for results. A board can drive effective execution through rigorous oversight of the management team’s performance, and in particular, by paying close attention to key performance data on quality and safety.

Constancy of Purpose It has become painfully clear to all those working to improve quality and safety that what hospitals require are not quick fixes. They require complete transformations.

The lessons from companies outside of health care like Toyota and other quality leaders indicate that organizational transformations require time, from 10 to 15 years or more.

In other words, given the turnover rate of hospital executives, “transformation is at least a three-CEO problem,” as one U.S. hospital leader phrased it. The quality and safety transformation cannot be the pet project of any one CEO. The board must function as a deep reservoir for constancy of purpose, if hospitals are to reach dramatic levels of improvement.

The good news is boards can do this job. And when hospital boards change their governing practices, and start to generate will, drive execution, and establish constancy of purpose, it makes a difference in measured quality results.14,15 The Institute for Healthcare Improvement has recognized this in the 5 Million Lives campaign to reduce harm in hospitals by placing major emphasis on the role of the board in safety.16

So, what do the best boards do to oversee quality and safety, and more practically speaking, how do they do it?


Give The Problem a Face

When Jim Conway was the COO of Dana Farber Cancer Institute, he visited another hospital to tell the story of Betsy Lehman, a *Boston Globe* health reporter who died in 1996 after a massive overdose of chemotherapy at Dana Farber. This experience catalyzed the transformation of Dana Farber Cancer Institute’s approach to patient safety.

After Conway’s presentation, a board member from the host hospital told him he was glad “those sorts of things don’t happen here.” When the CEO of that hospital interrupted to say that they in fact do happen there, the board member replied: “But you never told us.”

To the contrary, said the CEO, he had shown the board regular reports on the incidence of safety events and other quality data. “Yes,” answered the board member, “but you never told us in a way we could understand it.”

Telling a patient’s story is perhaps the most powerful way to communicate a problem so that trustees can understand it.

In fact, many boards now make it standard practice to start every Board Quality Committee meeting (and some full board meetings) with a brief patient story—often one about harm—to put a face on the data that the committee is about to review.

The story can be told by a nurse, doctor, or administrator, but is most powerful if told in person by the patient or family member. To avoid various pitfalls (e.g., spending the entire meeting discussing arcane medical details or getting bogged down in ad-hoc problem solving), it is best to follow a few guidelines:

- Make sure it is a story about an event in your hospital (to avoid the perception that this is someone else’s problem).
- Make it a recent event (to avoid the perception that, “We used to have that problem but we fixed it.”).
- Do not use patient or staff names (to avoid any temptation to blame individuals).
- If a staff member is telling the story, use a script to keep the story short, and avoid unneeded medical details).
- If you invite family members or patients to tell a story, meet with them in advance to make sure they focus on their experience of the event, rather than on medical details.
- If possible, provide current data relevant to the incident being discussed. For example, if the story is about a patient with a hospital-acquired central line infection, show the run chart of the number of such infections over the past year or two.

Giving the Problem a Face: The Delnor-Community Quality Committee Example

Delnor-Community Hospital in Geneva, Illinois, has adopted the practice of telling a patient story at the start of every Quality Committee meeting. The Committee invited an 81-year-old patient who had undergone three months of procedures and treatments for an infection that occurred after a June hip replacement. The retired machinist took just ten minutes to describe the three-month experience he referred to as his ‘lost summer.’ “And I’m 81,” he added, “so I don’t have many summers left.”

The next item on the Committee’s agenda was a review of surgical site infection rates. With the story of the ‘lost summer’ ringing in their ears, the Committee members started asking very pointed questions about surgical site infections, with an invigorated sense of ‘will’ to improve performance.
Mind the Gap

Another way in which boards can generate will is to ask administrators, “Who is the best in the world at this?” The gap between current performance and ‘best in the world’ is a strong source of energy for improvement.

There is an important difference between asking, “Who is the best in the world” and “How do we compare to others?” Too often, the answer to the second question is comforting framed, in reference to deciles of performance, or the median. Statements such as, “We’re better than the average performance for hospitals like us,” or perhaps, “We’re in the top 25% of hospitals in this dimension of safety”, tend to be comforting answers for a board to hear, and reinforce the status quo.

On the other hand, statements such as, “We may be better than average, but the best hospitals in the world have 10 times fewer infections than we do!” drive the board to ask, “Why can’t we do that?”

One excellent practice is to put the ‘best in the world’ line on every run chart or other graphic display of performance, so that the board sees the gap at every opportunity.

The following display from the Institute for Healthcare Improvement’s “Toyota Specifications for Healthcare” is a good example of how “minding the gap” can build and maintain the will to make necessary changes.

Be Transparent

It is good to be aware of a quality or safety gap in the boardroom, but it is even better to extend that awareness to the entire organization, and to the patients and community being served. There is no more powerful a method to create a will to improve than by making public the hospital’s performance.

After all, “If you’re going to be naked, it’s good to be buff”.

It takes courage to adopt policies involving real transparency. Boards (and executive leaders) often express fear that if they go public with their less-than-optimal data, patients will leave them and go to competitors, malpractice lawyers will pounce on the data, and regulators will descend on the organization. It is therefore common for hospitals to show only their best data.

But there is no evidence that patients leave hospitals when these institutions forthrightly report all their quality and safety data (the good and the bad) nor is there evidence that these reports invite lawsuits and regulatory inspections.

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There is, however, good evidence that transparency drives hospitals to improve, especially in areas of performance that are ripe for improvement.

Cincinnati Children’s Hospital offers a dramatic example of transparency. When Lee Carter, Chair of the Board, learned along with the rest of the board that children in the hospital’s care experienced serious harm once every 21 days, Carter and the board set an aim to reduce this rate dramatically, and quickly, targeting an 80% reduction within 18 months.

The board approved a policy of complete transparency about patient safety and harm as one of the strategies to achieve this aim. As a result, the screen saver on every computer in the hospital now prominently displays the number of days since a child was last harmed.

All staff, as well as patients and families, see this number each time they look at a computer. And when the number goes to zero, as it does now and then when a new harm event has occurred, a new box appears on the screen saver that allows staff and parents to read a short description of what happened, so that all can learn from the mishap and be better prepared to avoid that sort of harm event.

Needless to say, everyone in the Cincinnati Children’s, (including parents) are acutely aware of the hospital’s effort to reduce harm to the children in their care, and safety has improved dramatically. And the “Days Since Last Harm” ticker returns to zero far less often today than it did a year ago.

Courageous boards that encourage management to show quality and safety performance data to all staff, patients, and community, will find that they have harnessed a potent force for improvement: the will to shape up.
The Achilles heel of most major change efforts is not a failure of will or ideas. It is the failure to execute. So, how can boards drive successful execution?

**Set Clear Aims**

When it comes to finance, boards are adept at setting very clear aims. For example, if the hospital will be going to the bond market in two years, the board might state an aim to achieve 140 days cash on hand within 18 months because it knows this will be an important factor in the hospital’s bond rating.

The best boards are now setting quality and safety aims with similar clarity by declaring how safe or how good the hospital needs to be, by what date, and how it will be measured.

The Cincinnati Childrens’ target is an excellent example. “We will become 80% safer, as measured by the Serious Safety Event rate, within 18 months.” Another great example is the five-hospital Wellstar system in Atlanta that targeted dropping hospital-acquired infections by 50% in FY 2008. Or the 70+ hospitals of the Ascension system that have been driving toward a stunningly clear aim, adopted in 2003 by their board: zero preventable deaths and harm within five years.

While clear aims improve execution, murky aims can actually hamper it:

- **Murky aims beget murky accountability.** If the board cannot state and measure what it wants the executive team to achieve, it is very difficult to hold them to account.
- **Murky aims beget murky plans.** A plan that ‘hopes to be better someday’ cannot be easily broken down into actionable steps. On the other hand, clear, crisp aims tend to drive the creation of well-prioritized, well-resourced plans with the necessary scale, pace, and depth to achieve real results.

Boards can drive execution by ensuring that quality and safety aims are framed using questions such as How good? By when? And measured how?

**Channel Attention to Quality**

Boards that are serious about quality spend at least 25% of their time on it. For those boards, the Quality Report is not on the ‘consent agenda,’ but is a major feature of each meeting, often the first item on the agenda. Through this basic practice, the board sends a powerful message that it is paying attention to quality.

What the board pays attention to gets the attention of management. And what management is paying attention to tends to be noticed throughout the organization.

Then execution becomes more likely, because when everyone in the organization understands that the board is serious.

That is when previously insurmountable barriers melt away, resources somehow become available, and things get done.

It is an excellent practice to do an audit of how the board spends its time. This can be done as a rough estimate based on memory of past meetings, but it is even better if a prospective actual time measurement is made.

If you find that the full board is not spending at least 25% of its time overseeing quality and safety, consider revising your allocation of the board’s time. After all, “the currency of leadership is attention.”

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Spend Quality Time on Quality... and Watch your Dots

While it helps execution to have boards spend at least 25% of their time on quality, it is even better when that time is well spent. Good quality activities can include hearing patients’ stories, performing probing reviews of quality performance, and asking hard questions of management and medical staff leaders.

Many trustees, however, find that their boards waste the time allotted for quality on listening to lengthy reports about specific quality projects (in many cases about the ones that have gone particularly well). They sit passively while a few medical staff leaders get sidetracked into technical discussions about the evidence base for a particular practice, or listen to detailed excuses about the inadequacies in the national hospital quality performance ranking and how it is a poor judge of their hospital.

But how do the best boards avoid these traps and make sure they spend quality time on quality? Instead of focusing quality discussions on answering: How good are we?, the board focuses on the question: Are we getting better?

When boards ask: How good are we?, the answer is almost always framed in comparative terms:

- “Our central line infection rate is better than the average for the University Health Consortium.”
- “We rank above the 75th decile for U.S. hospitals in our CMS Core Measures of evidence-based care.”

These compared-to-others measures are perfectly fine for annual stock taking but are usually not helpful for the regular board reviews that drive execution. They almost always involve a four- to six-month delay in the feedback loop, during which data is pooled from many hospitals, processed, and then sent back to individual hospitals as percentile rankings, comparisons to average, and so forth.

If the board (and therefore management) is focusing on measures that are six months old, how can they respond with timely changes in strategy, key project leadership, or other needed adjustments?

For regular reviews of performance, the best boards focus on their own hospital’s performance data over time. It is information designed to answer questions such as, “Are we on track to achieve our aim of 80% reduction in Serious Safety Events?”, and “Are we reducing the number of hospital-acquired infections in our system?”

These reports can be current (no more than a month old), do not need to be risk-adjusted (your patient population is pretty much the same from month to month) and do not even need to be expressed as rates (per thousand ICU days, per 1000 drug doses).

This last point is important, especially when the board’s quality aim is expressed relative to the ‘theoretical ideal’ (usually zero or 100%). When the aim is zero hospital-acquired infections, the board can simply track the number of infections rather than seeing an abstract figure expressed as ’X infections per 1000 line-days.’

Not only is this easier for lay board members to understand, but it also encourages them to ask far more rigorous questions. And when lay board members ask management and medical leaders: “Why are we still having these infections when the best hospitals in the world have essentially eliminated them?”, it tends to drive the execution of needed changes in strategies like hand-washing, along with higher levels of rigor in other preventive practices.

One of the best ways to drive quality and safety execution is to watch your own dots, constantly asking yourselves the question “Are we getting better—are we on pace to achieve our aims?”
If it is true that the quality transformation of health care systems will take at least 10 to 15 years, how do boards dig in for the long-term?

**Establish a Quality Committee**

It sounds very basic, but boards that intend to take quality seriously for the long haul establish a committee that oversees quality with the same rigor the Finance Committee applies to finances.

Embedding this review process in the committee structure of the board makes a strong statement about the permanence of quality as a key organizational strategy, and reduces the likelihood that the board’s attention will stray to other matters as the months and years go by.

The design and processes of the best hospital Board Quality Committees, such as those at Allina in Minneapolis, and Delnor-Community in Geneva, Illinois, include the following features:

- The board appoints its best trustees to the Quality Committee (i.e., this is a “prestigious” assignment for a board member).
- The chair or vice-chair of the board is a lead member of the Quality Committee (another strong signal about the importance of this work).
- Lay trustees with expertise in quality (e.g., a manufacturing executive whose company has a long history of using ‘lean production’ methods) are specifically recruited to the board and appointed to the Quality Committee.
- The agenda of the committee meetings is driven primarily by the board members rather than by the administration.
- The committee meets monthly.
- Every meeting begins with a brief patient story to put a face to the data being considered during that meeting.
- The committee regularly reviews data focusing on the question, Are we on track to achieve our aims?
- The committee meetings are characterized by vigorous conversations with medical staff leaders and administrators about policies and strategies to achieve the aims.
- The committee considers and approves policies and strategies to improve the likelihood of achieving the quality and safety aims (i.e., the Quality Committee does not just listen and discuss, it acts).
- The Quality Committee reports to the board at every board meeting, with the Chair of the Quality Committee in the lead (i.e. the Quality Committee report is not given by the “quality staff” but by the lead director).

**Send Strong Cultural Signals**

Structures and processes are important.

But an even more enduring force—one with the staying power to maintain constancy of purpose over many years—is the hospital’s culture.

This is a set of habits and patterns of behavior and the underlying beliefs and values that prevail in the hospital. For example, one widespread cultural pattern among nurses might be stated as: “We nurses follow the safety policies such as hand-washing… unless we’re really busy.” Another example, common among doctors, is “These safety guidelines are good for everyone else, but they don’t apply to me.”

How, then, do the best boards send signals to replace these widespread and hazardous cultural rules with a new, better set of habits and patterns? The following offer some excellent examples.
What Do You Do when Times Are Tough?
One unwritten cultural rule in many hospitals is that when times get tough, financial concerns trump quality and safety. A good example of this is nurse staffing.

Since nurses are the single largest expense of any hospital, when financial pressures arise nurse staffing ratios are often squeezed. And charge nurses, who traditionally act as a vital backup resource for nurses who are struggling with a difficult patient load, or a new procedure, are seen as a luxury in tight times, and are asked to assume direct patient care responsibilities in the interest of ‘productivity.’

In other words, in most hospitals, hard financial times lead to higher nurse workloads and lower levels of experienced backup for nurses—a combination that usually leads directly to higher safety risks, but not at Inova Health System in Fairfax, Virginia.

Inova has adopted a policy that dictates “nurse staffing will be at least at the median level of staffing nationally, and a charge nurse without direct patient care responsibilities will be present on each shift.”

The policy, which is dramatically different from the experience of most nurses in most hospitals, has sent a clear, new cultural signal to the managers and staff at Inova. One that says: this board is putting safety above finance. This signal will provide unambiguous cultural guidance for many other decisions made throughout Inova for years to come when the tension between money and safety arises.

Interestingly, this particular policy was also found to help deal with the “I can’t follow the safety rules because I’m too busy” pattern of behavior, because if solid staffing and flexible backup systems are in place, it then becomes reasonable to expect front line nurses to follow the safety rules.

Give Patients And Families a Seat In the Power Structure.
A long-standing cultural rule in many hospitals might be stated as: “Patients and families have their place, and it’s in the waiting room.” Dana Farber Cancer Institute in Boston and St. Joseph’s PeaceHealth in Bellingham Washington have been leading a break away from that rule by inviting patients and families into all the decision-making processes and committees of the hospital, including all the powerful committees of the board such as Finance, Strategic Planning, and Quality.

Recently, St. Joseph’s PeaceHealth has even taken the unprecedented step of asking a patient to become a member of the Medical Executive Committee, (MEC) which carries out credentialing, peer review, and other professional activities of the organized medical staff.

Somewhat nervous about this radical change, the members of the MEC initially asked the patient to leave the room whenever they discussed sensitive matters having to do with physician quality. As the months wore on, however, they stopped asking the patient to leave. After a year of this, the doctors asked to make the patient a full member of the committee, with full voting rights on every issue. The physicians report that the patient’s presence has had a remarkable effect on their conversations.

What was once considered “routine squabbling among departments” and “strong advocacy for physician autonomy” now sounds unseemly, and of minor importance because the patient’s presence in the room reminds the doctors that the primary purpose of the MEC is to improve professional care for patients, not to protect incomes, habits or physician convenience.

Boards can make a dramatic impact on the culture of an organization by welcoming patients and families into key committees, design groups, and improvement teams. And the beauty of this step
is that it is lasting. Once boards set a course down this road, there seems to be no going back. And as Dana Farber’s leaders would say about patient involvement, “We can’t imagine how we ever ran the institution without them.”

Don’t Flinch.
Almost every board is regularly tested on its commitment to quality and safety. The most common circumstance arises when the Medical Executive Committee reports to the board on something like medical record delinquencies (when doctors have not completed operative notes or discharge summaries in a timely manner—which can have an impact on quality of care.)

Such delinquencies are annoyingly common in many hospitals, and MECs and boards usually regard suspending the privileges of the physicians involved as a rather drastic step. But the reluctance to act sends a cultural signal that, while the hospital adopts policies on quality and safety, there will not be consequences if you do not adhere to those policies.

It should come as no surprise then, that when other new safety policies are adopted by the board, these might also be ignored by some medical staff under the cultural rules “that must not apply to me” and “there won’t be any consequences, anyway.”

As a result, really important safety policies such as full barrier precautions for central line insertions, and mandatory timeouts before surgery, are followed by most, but not all doctors, without apparent consequence—except to the patients that suffer hospital-acquired infections and wrong site surgeries.

Boards of hospitals such as McLeod Regional in Florence, South Carolina, have started to send different signals to drive long-term cultural changes.

When a prominent doctor was persistently delinquent in timely medical records completion, the board suspended his operating privileges, even though it meant that a major surgical program essentially had to shut down for two weeks. In the end, the doctor updated his charts, the program re-started, and everyone in McLeod felt that the board had sent a strong new signal, namely, that this hospital is serious about quality and safety. As a result, observance of all safety policies and practices—hand-washing, barrier precautions, time-outs—improved.

Every board faces these kinds of tests, at almost every meeting. The question is not whether the board will send a cultural signal. The question is whether you will send the right signal, without exception. In other words, don’t flinch.
Hospital boards are beginning to realize that they can no longer regard the quality and safety of care in the hospital as the responsibility of the doctors and nurses. Even though most hospital board members are not clinically trained, they are nevertheless ultimately responsible for everything that goes on in the hospital, including the quality of clinical care.

The best boards are learning about how lay trustees can do an effective job of quality and safety oversight. This short paper describes three arenas of work for boards: building the will to improve, driving execution of changes, and creating constancy of purpose for the long haul. But more importantly, it offers a practical perspective on what the best boards are doing to make these three arenas effective.

Boards can build will by putting a face on safety and quality problems, by becoming and staying aware of the gap between current performance and the best in the world, and by being transparent, that is to say, by displaying all their quality data, good or bad, to the public.

Boards can drive execution by setting clear quality and safety aims, seeking to answer, How good? By when? And how will it be measured? They should also spend at least 25% of their time on quality. And they should spend that time well, specifically by always asking for data on the question: Are we on track to achieve our aims?

Finally, boards can create constancy of purpose for the long haul by establishing a structural foundation in a strong Board Quality Committee. Boards should also be conscious of the importance of the signals they send and what role these have in transforming a hospital’s culture.

The best boards send signals that safety is more important than productivity; make patients and families full members of the care team; and most importantly, when tested will be steadfast in their support of quality and safety.
APPENDIX: CHECKLIST FOR ENSURING PERFORMANCE OF A BOARD’S QUALITY RESPONSIBILITY

1. Do we have a quality Board? Have we recruited the skills and experience required?

2. Do we operate at a fiduciary standard? Does board behaviour contribute to or detract from board performance?

3. Do we understand our role and our areas of responsibility, particularly as they relate to quality?

4. Is there a healthy board/management relationship? Does the board understand and properly discharge its management oversight role?

5. Are there board leadership issues that impact the board’s performance of its role?

6. Are meetings managed in a manner that ensures a focus on quality?

7. Is the board effectively using its Committees to enhance board performance of its role for quality? Has the board established a Quality Committee?

8. Is the board doing ongoing education and evaluation of its governance structures and processes including its own performance with specific reference to quality?

9. Does the performance measurement system used by the board meet the following criteria:
   (a) A specific process has been adopted;
   (b) Indicators are linked to strategic plan and annual plan;
   (c) Measures and indicators focus on results;
   (d) Tools have been adopted to allow for comparisons of actual to planned, actual to benchmarks, actual to acceptable ranges;
   (e) Responsibility for providing information and evaluation is clear; and,
   (f) There is a process to react to variances.

10. Do we understand the role of management and the role of the board with respect to remediation plans and are we prepared to act when necessary?
APPENDIX: SUGGESTED RESOURCES

Accreditation Canada
www.accreditation-canada.ca

Canadian Institute of Health Information
www.cihi.ca

Canadian Patient Safety Institute
www.patientsafetyinstitute.ca

Institute for Family-Centered Care
www.familycenteredcare.org

Institute for Healthcare Improvement
www.ihi.org

National Health Service – National Patient Safety Agency
www.npsa.nhs.uk

National Quality Forum
www.qualityforum.org

Ontario Health Quality Council
www.ohqc.ca

Ontario Hospital Association
www.oha.com

Safer Healthcare Now!
www.saferhealthcarenow.ca

The Governance Institute
www.governanceinstitute.com

The Joint Commission Journal on Quality and Patient Safety
www.jcrinc.com