

# The Quality System Blueprint

A maturity-adaptive set of templates for standing up a hospital quality program, constituting its committees, and building a living quality system.

Adapt each template to your organisation.

1. Quality & Patient Safety Program Charter
2. Quality Committee — Terms of Reference (Template)
3. Quality System Maturity Rubric
4. Balanced Quality Scorecard (Template)
5. Board-to-Bedside Accountability Map (RACI)
6. Quality Program — 90-Day Implementation Roadmap

## Quality & Patient Safety Program Charter

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This charter establishes the Quality & Patient Safety Program for [ Organisation name ] and authorises the bodies that govern it. It is approved by the Board and reviewed annually.

### 1. Purpose

To provide a single, accountable system for measuring, improving and assuring the quality and safety of care across every area of the organisation — and for feeding what is learned back into practice.

### 2. Scope

- All clinical and non-clinical services and sites operated by the organisation
- Patient safety, clinical effectiveness, patient experience, access and equity

- Both assurance (are we safe?) and improvement (are we getting better?)

### 3. Objectives

- Reduce avoidable harm and unwarranted variation in care
- Establish a measurement system spanning structure, process and outcome
- Build frontline improvement capability and patient/staff voice channels
- Achieve and sustain relevant accreditation and standards
- Grow a just, learning safety culture

### 4. Governance & authority

The Board holds ultimate accountability for quality. It delegates oversight to the Board Quality & Safety Committee, which directs the Executive Quality & Safety Committee, which in turn coordinates operational and unit-based quality work. Each body operates under its own terms of reference.

### 5. Roles to be named

Executive sponsor (accountable officer)

Quality & safety lead

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Board committee chair

Clinical governance lead

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Patient/family representative(s)

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### 6. Resources

The organisation commits the people, time, data infrastructure and budget required to deliver this program, to be reviewed annually as part of business planning.

### 7. Review & approval

Approved by (Board chair)

Date approved

----- signature

----- [ date ]

Next review date

----- [ + 12 months ]

**Note** · Adapt the bracketed fields to your organisation. Keep the charter to two pages — it is a mandate, not a manual.

# Quality Committee — Terms of Reference (Template)

Use one copy of this template per committee (Board Quality, Executive Quality, Operational Quality, and each standing domain committee). Complete every field before the first meeting.

## Committee identity

Committee name

Accountable to (parent committee)

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Chair / deputy chair

Secretariat

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## Purpose

State, in one or two sentences, what this committee exists to assure or improve and the part of the system it covers.

## Duties

- Review the agreed scorecard and exception reports each meeting
- Commission, monitor and close improvement actions
- Escalate risks that exceed its authority to the parent committee
- Assure compliance with relevant standards and policies
- Receive patient/staff voice and incident learning relevant to its scope

## Membership & quorum

Core members (roles, not names)

Standing attendees

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Quorum

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e.g. chair + 50% of members

## Operating rhythm

Item	Standard
Frequency	[ monthly / quarterly ]
Agenda issued	[ 5 working days before ]
Papers issued	[ 3 working days before ]
Minutes & actions issued	[ within 5 working days ]
Decision rights	[ what this committee may decide vs. recommend ]

## Reporting

This committee reports a summary of decisions, risks and assurance to its parent committee after each meeting, and provides an annual effectiveness review.

**Note** · A committee with no decision rights and no scorecard is a meeting, not a governance body. Make both explicit.

# Quality System Maturity Rubric

Score each dimension against the level that best describes your organisation today. The lowest-scoring dimensions are your priorities; the overall pattern points to the right solution track.

Dimension	1 — Latent	2 — Reactive	3 — Structured	4 — Proactive	5 — Gene
Accountability	No clear owner	Named lead, surveyed	Chartered committee & roles	Owned at every level	Embe in ho work done
Measurement	Data for returns only	Pulled when needed	Regular scorecard	SPC drives decisions	Real-sensi
Reporting	Rare; blame feared	Serious events only	System used routinely	Trusted & acted upon	Weak signa surfa early
Voice	Not collected	Surveys, loop not closed	Feeds regular review	Shapes priorities	Partn desig
Improvement	Individual initiative	Event-triggered	Defined method, some projects	Frontline PDSA	How is doi
Culture	Blame; silence	Varies by unit	Just culture stated	Psychological safety real	Self-corre
Learning	Gains fade	Hard to sustain	Standard work holds gains	Reliability engineered	Conti rede

**Note** · Prefer the interactive version? Take the self-assessment at [ruavira.org/workflow/assessment](https://ruavira.org/workflow/assessment) for an instant score and a recommended track.

## Balanced Quality Scorecard (Template)

Populate one row per indicator. Keep the set small enough to review every meeting. Each indicator needs a definition, a target, a data source, a frequency and a named owner — an indicator without these is a number, not a measure.

Domain	Example indicator	Target	Source	Frequency	Owner
Safe	Falls with harm per 1,000 bed-days	[ ]	[ ]	Monthly	[ ]
Safe	Healthcare-associated infection rate	[ ]	[ ]	Monthly	[ ]
Effective	Care-bundle compliance (%)	[ ]	[ ]	Monthly	[ ]
Effective	Risk-adjusted mortality	[ ]	[ ]	Quarterly	[ ]
Patient-centred	Patient experience score	[ ]	[ ]	Monthly	[ ]
Timely	Time to treatment / wait	[ ]	[ ]	Monthly	[ ]
Efficient	Length of stay vs. expected	[ ]	[ ]	Monthly	[ ]
Equitable	Outcome gap across groups	[ ]	[ ]	Quarterly	[ ]

**Note** · Display each indicator as a run or control chart, not a single number against last month — variation, not the latest point, is what tells you whether to act.

# Board-to-Bedside Accountability Map (RACI)

R = Responsible (does the work) · A = Accountable (answerable; one per row) · C = Consulted · I = Informed. Adapt roles to your structure; ensure exactly one A per row.

Activity	Board	Exec Quality Cttee	Ops Quality Cttee	Domain Cttees	Unit Teams
Approve quality strategy	A	R	C	I	I
Set & monitor scorecard	I	A	R	C	C
Run improvement projects	I	I	C	C	R/A
Manage incidents & learning	I	C	A	R	R
Assure accreditation	I	A	R	C	C
Foster safety culture	A	R	R	C	R

**Note** · If a row has no A, no one is answerable. If it has several A's, no one is. Fix both before you publish it.

# Quality Program — 90-Day Implementation Roadmap

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A pragmatic sequence for standing up the program. Timings are indicative — compress or extend to fit your context, but keep the order.

## Phase 0 — Diagnose (weeks 1-2)

- Complete the maturity self-assessment and gap analysis
- Map stakeholders and confirm executive sponsorship
- Agree the target maturity move and solution track

## Phase 1 — Design (weeks 3-5)

- Draft and approve the program charter
- Complete committee terms of reference and the accountability map
- Define the starter scorecard and indicator owners

## Phase 2 — Stand up (weeks 6-8)

- Convene committees and induct members
- Launch incident reporting and the scorecard
- Train initial improvement and patient-safety capability

## Phase 3 — Operate (weeks 9-12)

- Run the first full governance cycle end to end
- Start unit-based PDSA cycles against priorities
- Report assurance to the board and feed decisions back to the frontline

## Beyond 90 days — Mature

- Engineer reliability into high-risk processes
- Build the just-culture and learning-system disciplines
- Re-run the maturity assessment and plan the next move

Milestone	Target date	Owner
Charter approved	[ ]	[ ]
Committees convened	[ ]	[ ]
Scorecard live	[ ]	[ ]
First board assurance report	[ ]	[ ]
Re-assessment booked	[ ]	[ ]

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