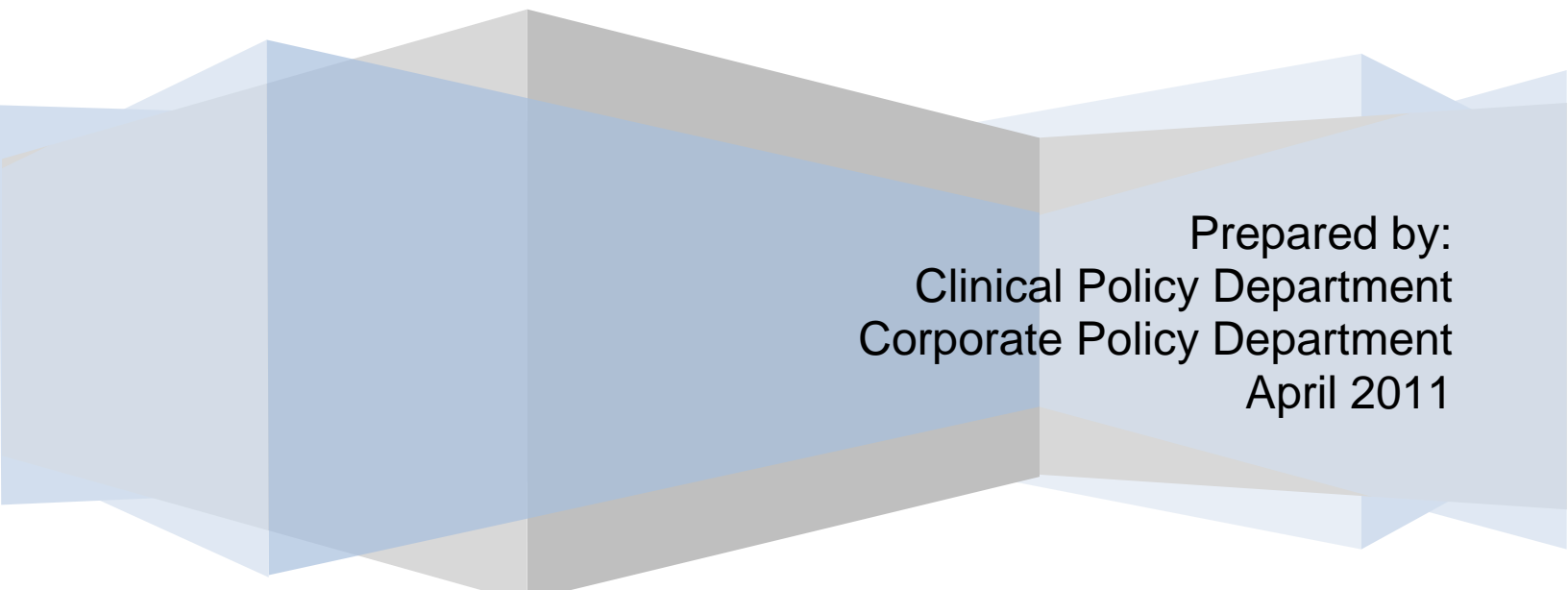


# Governance Document Framework

## Clinical and Corporate



Prepared by:  
Clinical Policy Department  
Corporate Policy Department  
April 2011

## Contents

<b>Executive Summary</b> .....	<b>1</b>
<b>Definitions</b> .....	<b>4</b>
<b>1.0 Introduction</b> .....	<b>5</b>
<b>1.1 Clinical Governance</b> .....	<b>5</b>
<b>1.2 Corporate Governance</b> .....	<b>5</b>
<b>2.0 AHS Governance Document Hierarchy and Influences</b> .....	<b>6</b>
<b>2.1 Governance Document Hierarchy</b> .....	<b>6</b>
<b>2.2 Internal Influences</b> .....	<b>15</b>
<b>2.3 External Influences</b> .....	<b>15</b>
<b>3.0 Accountabilities and Responsibilities</b> .....	<b>17</b>
<b>3.1 Clinical and Corporate Policy Departments</b> .....	<b>17</b>
<b>3.2 Executive Sponsor</b> .....	<b>18</b>
<b>3.3 Sponsor</b> .....	<b>18</b>
<b>3.4 Working Group</b> .....	<b>19</b>
<b>3.5 Key Stakeholders</b> .....	<b>19</b>
<b>3.6 Internal Review Groups</b> .....	<b>20</b>
<b>4.0 Governance Document Cycle Elements</b> .....	<b>21</b>
<b>4.1 Initiation</b> .....	<b>21</b>
<b>4.2 Development</b> .....	<b>22</b>
<b>4.3 Consultation</b> .....	<b>22</b>
<b>4.4 Endorsement and Approval</b> .....	<b>23</b>
<b>4.5 Implementation: Communication, Education, and Practice     Change</b> .....	<b>23</b>
<b>4.6 Evaluation</b> .....	<b>24</b>
<b>4.7 Review</b> .....	<b>24</b>
<b>Contacts</b> .....	<b>25</b>
<b>Appendix “A”</b> .....	<b>26</b>

© 2011 Alberta Health Services

This document is protected by Canadian copyright law. Except as otherwise provided for under Canadian copyright law, this document may not be copied, published, or distributed without the prior written permission of the copyright owner.

## Executive Summary

The purpose of this Governance Document Framework (Framework) is to establish the governance documents that provide direction to employees, medical and other professional staff, volunteers, and others who act on behalf of AHS, and to standardize the processes for developing and implementing clear, concise, well-written documents within Alberta Health Services (AHS). The Framework also enables individuals to understand and comply with legislative, legal, professional, and organizational requirements, expectations, and standards.

### *Compliance with Framework*

The accountability and responsibility for governance documents is shared among the AHS Board, Executive Committee, Senior Executive, management, medical and other professional staff, and the employees.

### *Governance Document Hierarchy*

The Governance Document hierarchy supports AHS' governance and operational needs and provides adaptability and flexibility in the face of internal and external influences.

- **Bylaw:** fulfills specific governance requirements as set out in legislation pertinent to a health authority and provides guidance for its operations.
- **AHS Code of Conduct:** outlines the values, principles, and standards of conduct that guide our actions and interactions.
- **Principle Statement:** high level, Board-approved statement on overarching governance, health system, and operational issues that reflect AHS' vision, mission, and values. Each governance document adopted throughout AHS must be consistent with the Principle Statement.
- **Policy:** sets out the organization's position on a specific subject, providing a common frame of reference and direction by establishing minimum requirements and expectations, benefiting those we serve and those within the organization. The policies for AHS are divided into three levels to facilitate operational effectiveness and efficiency.
  - **Level 1 Policy:** the highest level of AHS policy that sets out requirements fundamental or significant to the mandate of AHS and the overall clinical and/or corporate goals of AHS.
  - **Level 2 Policy:** meets an identified need to establish operational requirements on a specific subject matter for two or more clinical and/or corporate departments.

- **Level 3 Policy:** addresses the needs of day-to-day operations for a single department or division.
- **Directive:** provides temporary governance in exceptional circumstances and offers instruction and guidance for decision-making and actions to support day-to-day operations.
- **Procedure:** provides detailed information necessary to fulfill requirements for a specific process.
- **Practice support document:** accommodates the unique nature of a department and is aimed at facilitating decisions or streamlining a particular process within a department's routine boundaries. In order of authority, it includes: **Standard** or **Code of Practice**, **Protocol**, and **Guideline**.

### *Governance Document Cycle Elements*

Governance document development and implementation involves collaboration among clinical and/or corporate policy departments, sponsors, and stakeholders. The following is a brief description of each element in the document cycle; these elements provide direction and guidance for upholding legislative and legal requirements, promoting best practices, mitigating risk, and supporting industry and professional standards. More importantly, the elements ensure that engagement with employees, medical and other professional staff, leaders, and other stakeholders takes place to identify resources, infrastructure, communication, practice change, and education necessary to support the development and implementation of governance documents.

**Initiation:** Issues or ideas can arise at any level within the organization. Once identified, issues/ideas are typically presented to the department with primary responsibility to determine initial feasibility to explore development. A representative from the department contacts an AHS policy representative to clearly identify the issue and need for a governance document.

**Development:** The development process is a collaborative and iterative activity among employees, medical and other professional staff, and leaders who have the content knowledge and expertise, and the policy representative. Under the lead of a sponsor, development includes an assessment of the issue to establish the overall plan for document preparation, consultation, and implementation, including the identification of resources, infrastructure, key stakeholder employees, medical and other professional staff, and other groups to consult, and practice change, education, and evaluation strategies to support the document.

**Consultation:** Consultation with employee and medical and other professional staff and, if required, external stakeholders ensures that broad organizational issues related to the governance document are identified early to minimize anticipated operational risks or



problems associated with implementation. This element is linked directly with development and is an iterative process.

**Endorsement and Approval:** Endorsement of a governance document by relevant teams or committees of employees, medical and other professional staff, and senior leaders identified during development, consultation, and engagement secures support for the requirements set out in a governance document. Approval demonstrates the organization's commitment to uphold the requirements set out in a governance document. The authority for approval varies based on the type of document.

**Implementation:** The sponsor manages the implementation process, including resource management, communication and educational and practice change activities identified during the development and consultation stages. Management and department leaders ensure others in the department receive information regarding new or revised governance documents. The policy representative participates in the dissemination of the information using a variety of available resources.

**Evaluation:** assesses success in achieving desired outcomes and compliance identified during the various stages of a document's life cycle.

**Review (periodic and ad hoc):** provides a regular opportunity for careful consideration of existing governance documents. An ad hoc document review may occur when changes are made to practice, legislation, law, industry, or professional standards.

## Definitions

We acknowledge there are many different definitions in use throughout AHS; however, the definitions provided below are for the sole purposes of this document.

**Department** - the functional area within AHS' organizational structure which is under the leadership of a VP or Medical Leader, or equivalent. This includes, but is not limited to: service, program, site, facility.

**Division** - the functional area within AHS' organizational structure which is under the leadership of an SVP or Medical Leader.

**Executive Committee** - The Executive Committee is the administrative decision-making body for overall AHS operations. The membership of the Executive Committee is the President and Chief Executive Officer and all Executive Vice-Presidents that report directly to the President and Chief Executive Officer.

**Portfolio** - the functional area within AHS' organizational structure which is under the leadership of an EVP.

**Senior Executive** - the President and Chief Executive Officer and all executive positions that report directly to the President and Chief Executive Officer and any other person designated by the President and Chief Executive Officer or the Board.

## 1.0 Introduction

Alberta Health Services' (AHS) mission is to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. An effective integrated governance document framework (Framework) is an essential component in support of the mission to improve:

- the delivery of care and services;
- support for people who deliver care and services; and
- the way the organization operates.

Governance documents reflect an organization's position, principles, standards, and processes on key issues. They guide the organization's operations and set out the expectations for its employees, medical and other professional staff, volunteers, students, contracted providers, and individuals who act on behalf of, or in conjunction with AHS. A single, consistent Framework establishes the types of documents that provide direction and puts in place standardized processes for developing and implementing clear, concise, well-written documents informed by evidence. It also enables individuals to understand and comply with legislative, legal, professional, and organizational requirements, expectations, and standards.

This Framework balances two distinct governance priorities of the organization which have unique needs, but share the common goal to fulfill AHS' mission, vision, and values.

### 1.1 *Clinical Governance*

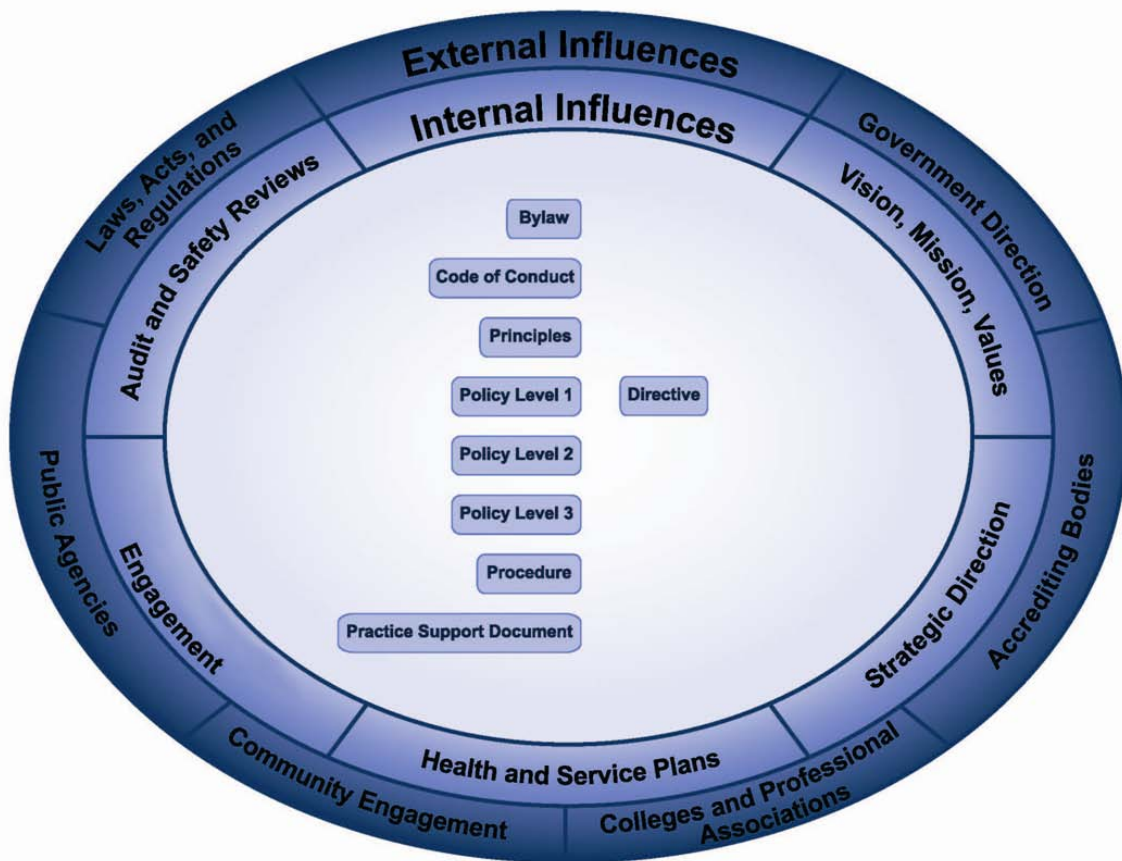
The key components of clinical governance encompass quality care and patient safety, and focus on a systematic and integrated approach to ensure a high standard of patient care. Clinical governance documents do not replace, but are in addition to professional self-regulation and individual accountability for clinical judgment that are an integral part of healthcare. Clinical governance documents are primarily concerned with patients and how they receive care and services and set out the responsibilities and expectations for the health care team in the delivery of clinical care.

### 1.2 *Corporate Governance*

Within AHS, corporate governance is fundamental to the strategic business direction of the organization and the operation of non-clinical areas such as human resources, financial management, expectations of conduct, and resource allocation and management. The focus of corporate governance documents is on corporate accountability, financial stewardship, procurement, human resources, and asset management to promote risk management strategies, to ensure legislative and legal compliance, and to establish sound business practices.

## 2.0 AHS Governance Document Hierarchy and Influences

AHS, like any major organization, adopts a document hierarchy that supports its governance and operational needs, and which provides adaptability and flexibility in the face of new and changing internal and external influences. This section describes AHS' document hierarchy and influences. A visual representation of the hierarchy and influences is provided below. At the core is the hierarchy of AHS' governance documents that provide guidance and direction to meet the organization's needs. Closest to the core, are the internal influences to which the governance documents are aligned. Finally, the external influences help shape the direction of the governance documents.



### 2.1 Governance Document Hierarchy

While the term “policy” is often used generically to describe the type of document that provides direction and sets out the ground rules for operations,

the dynamic nature of AHS dictates that broader, more flexible options are necessary. The AHS governance document structure ensures:

- a hierarchy is established and allows a variety of document options that best support the needs of senior leaders, medical and other professional staff, employees, and the organization in general;
- active participation of employees, medical and other professional staff, and other key individuals or groups at each stage of the document's life cycle as a cornerstone of engagement to fully embrace AHS' values;
- document approvals reflect the appropriate operational authority;
- address the level and type of document which will result in the most successful outcome for identified issues;
- dependant on the specific need, documents within the hierarchy can be developed independently of one another, or as a suite of documents; and
- there is a consistent approach across zones, services, divisions, areas, programs, and departments, et cetera.

The key to achieving sound, practical, and robust governance documents is collaboration. Within AHS this is accomplished by bringing together representatives from an array of divisions, departments, programs, disciplines, and professions who have the subject matter expertise and knowledge to guide and inform a particular document and to have in place an approval structure that ensures resources fully support the successful implementation of a governance document. Throughout this Framework, the critical component at each stage of the process is fostering an environment for meaningful engagement of employees, medical and other professional staff, volunteers, and other key individuals and groups.

The following sections describe each document within the structure, the placement within the hierarchy, responsibility, engagement and endorsement, the approval authority, scope, compliance requirements, and the review period. As well, the accountability and responsibility are identified; however, a fuller description of these two important components is provided in Section 3.

#### **a) Bylaw**

AHS bylaws fulfill specific governance requirements as set out in legislation pertinent to a health authority and provide guidance for its operations. The current legislated requirements for bylaws are:

- Borrowing (*Regional Health Authorities Act*)
- Community Health Councils (*Community Health Councils Regulation*)
- Conflict of Interest (*Regional Health Authorities Act*)
- General (*Hospitals Act and Regional Health Authorities Act*)
- Health Care Foundations (*Regional Health Authorities Foundation Regulation*)
- Investment (*Regional Health Authorities Act*)
- Medical Staff (*Hospitals Act*)

Accountability	Minister of Health and Wellness and AHS Board
Responsibility	AHS Board; Senior Executive; relevant portfolio Executive Vice President
Engagement and Endorsement	Identified employee, medical and other professional staff, and other key stakeholder groups
Approval	Minister of Health and Wellness, or as directed by applicable legislation A bylaw takes effect upon Ministerial approval Any amendment requires Ministerial approval
Scope	Organization; contracted entities- subject dependent
Review Period	Unless directed otherwise by legislation or the Board: <ul style="list-style-type: none"> <li>at least every three years for those bylaws with direct impact on operational needs (i.e., General, Medical Staff, Borrowing, Conflict of Interest, Investment); and</li> <li>at least once every five years for all other bylaws (i.e., Health Advisory Councils, Health Care Foundations).</li> </ul>

### ***b) Code of Conduct***

The AHS Code of Conduct (Code) outlines the values, principles, and standards of conduct that guide our actions and interactions. The Code is principles-based and anchors the rules by which we govern ourselves, which also includes bylaws, policies, procedures, standards, guidelines, protocols, and directives.

Accountability	AHS Board
Responsibility	Senior Executive; Ethics and Compliance Officer
Engagement and Endorsement	Identified employee, medical and other professional staff, and other key stakeholder groups
Approval	AHS Board and Executive Committee The Code takes effect upon Board approval Any amendment requires Board approval, unless directed otherwise

Scope	Organization; contracted entities, as required
Review Period	At least every three years, unless directed otherwise by the Board

### *c) Principle Statement*

Principle Statements are high level, Board-approved statements on overarching governance, health system, and operational issues that reflect AHS' vision, mission, and values. They support the strategic direction and establish the subject matter groups for governance document suites (e.g., policies, procedures, standards, and guidelines). Each governance document adopted throughout AHS must be consistent with the Principle Statements.

Accountability	AHS Board
Responsibility	President and Chief Executive Officer (or designate); Senior Executive
Engagement and Endorsement	Identified employee, medical and other professional staff, and other key stakeholder groups
Approval	AHS Board and Executive Committee A Principle Statement takes effect upon Board approval Any amendment requires Board approval, unless directed otherwise
Scope	Organization; contracted entities, as required
Review Period	At least every three years, unless directed otherwise by the Board

### *d) Policy*

An AHS policy sets out the organization's position on a specific subject. It provides a common frame of reference and direction by establishing the minimum requirements and expectations that benefit those we serve, employees, medical and other professional staff, volunteers, students, and in many cases, contracted service providers. Requirements in a policy may be further expanded upon through other governance documents such as procedures, protocols, standards, codes of practice, or guidelines.

The policies for AHS are divided into three levels to facilitate operational effectiveness and efficiency. While these levels will provide guidance to those sponsoring AHS policy work, other factors such as risk, legislative and regulatory requirements and directives from government could result in elevation of a policy up one or more levels. Consultation with Corporate or Clinical Policy is required in these circumstances.

### Level 1 Policy

This is the highest level of AHS policy. A Level 1 policy sets out requirements that are fundamental or significant to the mandate and the overall clinical and/or corporate goals of AHS. The prioritization of the Level 1 policies is determined by either the Board or Executive Committee, depending of the subject and accountability. Approval is granted in accordance with the accountability. Policies at this level are applicable across the organization (e.g., more than one portfolio) and may have more than one sponsor division.

Accountability	AHS Board or Senior Executive, subject dependant
Responsibility	Senior Executive (Board); Portfolio Executive Vice President(s) (Senior Executive)
Engagement and Endorsement	Identified employee, medical and other professional staff, and other key stakeholder groups
Approval	AHS Board or Executive Committee A Level 1 policy takes effect upon Board/ Executive Committee approval, or on the date identified at the time of approval Any amendment requires Board/ Executive Committee approval, unless directed otherwise
Scope	Organization; contracted entities, as required
Review Period	At least every three years, unless directed otherwise by the Board or Executive Committee

### Level 2 Policy

This level of policy meets an identified need to establish operational requirements on a specific subject matter for clinical and/or corporate divisions or departments. Level 2 policies impact one or more departments/divisions, and generally apply to a limited audience that is operationally responsible to comply with the policy's requirements, such as a program with multiple delivery sites.

Accountability	Portfolio Executive Vice President(s)
Responsibility	Division Senior Vice President(s) (or EVP direct report)
Engagement and Endorsement	Identified employee, medical and other professional staff, and other key stakeholder groups
Approval	Portfolio Executive Vice President(s), or higher A Level 2 policy takes effect upon portfolio Executive Vice President approval, or on the date identified at the time of approval Any amendment requires portfolio Executive Vice President approval, unless directed otherwise
Scope	Defined areas across AHS, subject dependent; contracted entities, as required
Review Period	At least every three years, unless directed otherwise by the Portfolio EVP(s)

### Level 3 Policy

At this level, a policy addresses the needs of day-to-day operations, which may include interpreting the requirements of level 1 or 2 policies or addressing issues specific to a single department. Level 3 policies apply only to a single department or division.

Accountability	Division Senior Vice President (or EVP direct report); Department Medical Lead
Responsibility	Vice President (or SVP direct report)
Engagement and Endorsement	Identified employee, medical and other professional staff, and other key stakeholder groups
Approval	Division Senior Vice President (or designate) A Level 3 policy takes effect upon approval, or on the date identified at the time of approval Any amendment requires division Senior Vice President (or designate) approval, unless directed otherwise

Scope	Division; contracted entities, as required
Review Period	As determined by department, but no less than every three years

### e) *Directive*

Directives provide temporary governance in exceptional circumstances. They offer instruction and guidance for decision-making and actions to support day-to-day operations (clinical and/or corporate) on a subject-specific basis. Directives may have organization-wide impact or may apply to limited audiences across the organization. Like policies, directives vary between corporate and clinical in order to meet the unique needs of these two areas.

#### Clinical Directives

- provide a mechanism to respond quickly to emergent issues, such as public health initiatives, identified policy gaps, or legislative changes;
- are time-limited and topic specific; and
- act as interim direction until emergent issues have been addressed or permanent governance documents have been developed.

#### Corporate Directives

- reflect organizational goals and objectives by providing direction for a standardized approach to business and operating practices;
- facilitate timely decision-making in the interests of quality service and cost-effective operations; and
- may be time-limited to fulfill immediate operational and business goals and objectives.

Accountability	Senior Executive
Responsibility	Portfolio Executive Vice President(s)
Engagement and Endorsement	Identified employee, medical and other professional staff, and other key stakeholder groups
Approval	Executive Committee A Directive takes effect upon Executive Committee approval, or on the date identified at the time of approval Any amendment requires Executive Committee approval, unless directed otherwise
Scope	Organization; contracted entities, as required

Review Period	Subject dependant, but at least every three years until replaced by a policy or rescinded
---------------	---

**f) Procedure**

Procedures are documents that provide detailed step by step information necessary to fulfill requirements set out in a higher level document. Procedures are associated with a higher level governance document, or may be attached to a Level 2 or 3 policy.

Accountability	As required, or same as higher level document
Responsibility	As required, or same as higher level document
Engagement and Endorsement	Identified employee, medical and other professional staff, and other key stakeholder groups
Approval	As required, or same as higher level document Procedure takes effect on the date identified at the time of approval Any amendment requires same level as original approval, unless directed otherwise
Scope	As required, or same as higher level document
Review Period	At least every three years

**g) Practice Support Documents**

Practice support documents accommodate the unique nature of a department and are aimed at fostering decisions or streamlining a particular process within a department's routine boundaries. They allow the opportunity to expand on the requirements set out in a higher level of governance document, government direction, legislation, or similar, to meet the operational needs and provide direction. In order of authority, the practice support documents include:

**Standard or Code of Practice** – sets out the desired and achievable level of performance that establishes best practice as may be established by national, provincial, or professional associations, and against which actual performance can be compared.



**Protocol** – prescribes interventions for undertaking specific investigations, therapies and/or activities in an identified situation, in either a clinical or corporate setting.

**Guideline** – establishes a recommended course of action that aligns with best practice, but individuals are afforded a reasonable amount of professional judgement in complying with the provisions.

Accountability	Department VP (or equivalent); Department Medical Lead; or Division leadership committee
Responsibility	Department Director (or equivalent)
Engagement and Endorsement	Identified employee, medical and other professional staff, and other key stakeholder groups
Approval	Department VP or Division leadership committee Standard, code of practice, protocol, guideline takes effect upon approval, or on the date identified at the time of approval. Any amendment requires same level as original approval, unless directed otherwise.
Scope	As required – may be same as Level 1, 2, 3 policy
Review Period	Department establishes, but at least every three years.

**Appendix to a governance document** - An appendix is a useful tool to provide supplementary reference information related to the requirements set out in the principal document. Reference information includes, but is not limited to a chart, an algorithm, or excerpts from other relevant documents. The information presented in an appendix may change from time to time and the responsibility for this information rests with the document sponsor, unless stated otherwise in the parent document.

## 2.2 *Internal Influences*

### ***Engagement***

Engagement with employees, medical and other professional staff, and others who are significantly affected by the requirements of a governance document is essential to promote optimal decision-making and ensures both meaningful and strategic priority setting that supports shared values and goals. Engagement takes place throughout each element of the policy cycle. The level of engagement is guided by several factors, including subject, impact on employees and medical and other professional staff, resources, and infrastructure.

### ***Audit, Safety Reviews***

Recommendations or requirements that arise from an internal audit review or a safety review (such as a Quarterly Patient Safety Review or a Workplace Health and Safety review) or other quality improvement initiatives, may reveal a governance gap or an area where an AHS governance document requires revision in order to reduce risk to patients, staff, and/or the organization.

### ***Vision, Mission, and Values, Strategic Direction, Health Plan, and Service Plans***

Governance documents are created in alignment with AHS' vision, mission, and values and core documents such as the strategic direction, health plan, and division and department service plans to support the unified delivery of service and governance throughout the organization.

## 2.3 *External Influences*

### ***Accrediting Bodies***

Accrediting bodies (such as Accreditation Canada, the Canadian Association for Laboratory Accreditation, the Trauma Association of Canada, and the College of Physicians and Surgeons of Alberta), often include specific requirements for governance documents in order to meet quality standards.

### ***Colleges, Professional Associations, and Public Agencies***

AHS may be influenced to align with organizations that develop professional practice requirements, such as the College of Physicians and Surgeons of Alberta (CPSA), the College and Association of Registered Nurses of Alberta (CARNA), Alberta Law Society, or the Institute of Chartered Accountants of Alberta. As well, AHS may desire to align with industry best practice, or national or international standards, such as those developed by the International Organization for Standardization (ISO).



### ***Community Engagement***

The community and general public (including patients and families) perception of various governance issues and concerns influence the actions of AHS. In many instances, governance documents for a specific topic area may not be mandated; however, the sensitivity and/or severity with which the public perceives these topics may warrant action. AHS may also develop governance documents as a community leader in health promotion matters such as tobacco and smoke free environments and trans fat reduction. Patients and families are engaged at various stages of the policy cycle to provide input and feedback on principles and content of relevant policies and supporting documents.

### ***Government Direction***

The Government of Alberta and AHS developed the *Mandate and Roles* document to articulate the commitment to a relationship of collaboration and cooperation, and to reflect a common understanding of their respective roles and responsibilities. This document provides guidance for the operations of AHS. In addition to the relationship with the Government of Alberta, other government or quasi-judicial bodies (such as the Office of the Information and Privacy Commissioner, or the Ombudsman) may identify requirements that are specific to a particular program or department.

### ***Laws, Acts, Regulations***

Compliance with laws and applicable federal and provincial legislation (acts and regulations) is a crucial component of governance documents and risk management for the organization. AHS is guided by over 40 acts, more than 80 regulations, and applicable laws.

### 3.0 Accountabilities and Responsibilities

Accountabilities and responsibilities mean different things. One is accountable “to” another individual or body, but is responsible “for” a particular task or event. Together, the accountability for governance documents is shared among the Alberta Health Services Board (Board), Executive Committee, Senior Executive, senior leaders, medical and other professional staff, and the individual employee. Each of us is accountable to the people of Alberta and to one another to ensure we comply with the requirements of the governance documents and support the AHS mission, vision, and values.

Responsibility for governance documents spans across the organization. The Board is responsible for ensuring that the appropriate governance, leadership, and administrative structures are in place. Senior Executive and management are responsible for ensuring the effective operation of those structures, and for informing individuals of the existence of these structures. AHS relies on individual accountability and the integrity of the individuals who provide care and services on its behalf to have an awareness of the structures and governance documents, and to exercise sound judgment in the performance of their roles and responsibilities.

The following section provides an overview of key participants and the role each plays in the governance document life cycle. The clinical and corporate policy departments provide manuals that offer support, guidance, and information on the accountabilities and responsibilities for governance documents throughout AHS. A table setting out an overview of accountabilities and responsibilities for the governance documents is included as Appendix “A”

#### 3.1 *Clinical and Corporate Policy Departments*

The management of processes for the governance documents is shared between the corporate and the clinical policy departments. Each policy department is accountable to their respective Senior Vice-President and is responsible for determining the overall organizational governance document strategies and processes to undertake to address issues for their respective areas of responsibility.

The respective policy department is also responsible for overseeing and guiding the governance document cycle processes, including determining the most appropriate document to address an issue, establishing governance document criteria for prioritization, leading or contributing to the development of specific governance documents and post-implementation evaluation and periodic review (see Appendix “A”), and monitoring new and revised legislation and emerging practices and trends that impact AHS operations. In keeping with this oversight role, each policy department is responsible for maintaining accurate listings of Level 1 and 2 policies:



- under development;
- approved.; and
- rescinded

As well, for specific governance documents (see Appendix “A”), the clinical and corporate policy departments are responsible for benchmarking, preparing and/or reviewing drafts for review and consultation, coordinating consultation feedback, ensuring appropriate endorsement and approval are in place, undertaking general publication and internal communication, and initiating periodic reviews.

In some circumstances, a distinction between the need for a clinical or a corporate governance document may not be clear. When these 'grey' area issues arise, the corporate and clinical policy teams will jointly determine the distinction and primary responsibility for development. The policy departments will also distinguish between topics requiring a governance document and those that will be addressed through health professions practice.

The Corporate and the Clinical Policy Departments are responsible for the Enterprise Content Management (ECM) system designed to manage the life-cycle of governance documents. The policy departments are responsible for the adoption of standardization methods, such as writing style and document naming conventions for their respective areas of responsibility.

### 3.2 *Executive Sponsor*

The Executive Sponsor is the member of the Senior Executive who has accountability for the subject matter addressed in a governance document. The Executive Sponsor commits to ensuring that the infrastructure and resources necessary to support the requirements of a governance document, including ensuring educational and practice change resources, will be in place as necessary. The Executive Sponsor acts as a decision-maker in the event of an impasse or dispute during the governance document process.

### 3.3 *Sponsor*

A sponsor is accountable to the relevant Executive Sponsor. Responsibility for governance documents is shared with the clinical or corporate policy representative and the sponsor (as described further within this document) who is the primary content expert during a document's development. The sponsor may delegate to a lead or may work directly with a policy representative in preparing drafts for review and consultation, coordinating consultation feedback, in communication and education, and in planning the implementation and evaluation strategies. A sponsor does not “own” the governance document as these are the records of AHS. The sponsor is responsible for the content of the document, but the processes and management of the document are the responsibility of the



respective policy representative, including the evaluation (post-implementation and periodic).

Due to the complexity of evaluating governance documents, the policy representative provides support to sponsors for the development of an evaluation strategy to be used to create an operational evaluation plan. The sponsor is responsible for managing the processes for evaluation. The sponsor makes arrangements for the operational activities associated with the evaluation of the document as identified during the development and consultation stages. If a significant issue related to the content is identified, the sponsor is responsible for taking remedial steps including revision. Any issues identified in the process are addressed by the policy representative.

### *3.4 Working Group*

It is of critical importance to address issues at the outset of developing a governance document to ensure the requirements do not impose an administrative or financial burden on any one department, program, site or profession without allowing for an opportunity to influence the outcome and seek equitable resolution.

Members of a working group are made up of the sponsor or a designated lead, employees, medical and other professional staff, senior leaders, and managers who have the subject matter knowledge and expertise to inform and guide the document content. These individuals represent the departments and/or areas which are most significantly affected by the core elements of a governance document, therefore, are critical to ensuring the success to the development and implementation. The working group collaborates to determine the most important elements of a governance document and the path to successful implementation. The sponsor (or delegate) and, in many cases, the policy representative, leads the working group in its activities.

### *3.5 Key Stakeholders*

The key stakeholders play a crucial role in the development and review of governance documents. As a normal practice, representative groups – referred to as key stakeholders - are requested to act as the spokespersons for the employees, medical and other professional staff, and others. They represent those who are most affected by the contents of a governance document in terms of compliance with the requirements. It is critical that the key stakeholders engage with the constituencies that they are representing, including front line staff, to obtain as broad a range of viewpoints as possible. Prior to approval of a document, key stakeholders are asked to provide feedback on the contents as a measure of good governance to ensure the

document adequately addresses the issue and establishes sound, practical, and achievable requirements. Moreover, the feedback identifies:

- any potential gaps or issues that must be addressed before implementation; and
- areas of concentration for communication, education, and practice change strategies.

### 3.6 *Internal Review Groups*

In addition to the key stakeholders, there are several groups within AHS that have an important role in reviewing governance documents as part of their legislated or legal mandate, or as part of their organizational responsibilities. In keeping with the commitment to provide quality health care and services, AHS has adopted a proactive approach that incorporates a review during a document's development. The decision to seek input from one or more of the internal groups is dictated by the subject matter of each governance document. The internal review groups include, but are not limited to the following (including successors as appropriate):

- Clinical Ethics
- Ethics and Compliance Office
- Health Professions Strategy and Practice
- Legal & Privacy
- Patient Concerns Officer
- Professional Practitioner Executive Committee
- Medical Administrative Committees/Councils, or as mandated by AHS Medical Staff Bylaws
- Patient Experience Department

## 4.0 Governance Document Cycle Elements

The Framework fully embraces the concept that governance document development and implementation are done in close alignment and collaboration with employees, medical and other professional staff, the clinical or the corporate policy department, sponsors, and stakeholders. The distinction among the various types of governance documents is an important consideration, not only when deciding how best to address an issue, but also in determining accountability, assigning responsibility, and allocating resources. Regardless of the type and level of governance document selected, there are several essential elements in the cycle, the key component of which is the engagement and participation of employees, medical and other professional staff, and other key stakeholders.

These elements ensure all types and levels of governance documents provide direction and guidance which uphold legislative and legal requirements, promote best practices, mitigate risk, and support industry and professional standards. As well, these elements result in governance documents which are clear, unambiguous, relevant, practical, and achievable. Generally, these elements apply to each type of governance document, but the level of involvement of sponsors, working groups, stakeholders, and policy representatives varies depending on the specific type of document. Appendix “A” sets out the roles for each specific type of governance document.

The following is a brief description of the elements. It is important to note that although presented in a staged format, or “steps”, the cycle elements require continuous consultation and collaboration that may require repeating one or more steps in the process.

### 4.1 *Initiation*

An issue or idea may arise at any level within the organization. The issue or idea is typically presented to the department with primary responsibility for the issue raised for determination of an appropriate resolution. If, after consideration of the issue, the department management is of the opinion that a Level 1 or Level 2 policy (including associated procedures) or a directive may be required, then a representative from the department contacts an AHS policy representative to ensure that the issue, and the need for a governance document, are clearly identified.

The distinction between a corporate or a clinical governance document may not always be clear as many issues have relevance in both areas. Similarly, clarification may be required between topics that require AHS governance document development versus those to address through health professions practice. In both cases, the corporate and clinical policy teams assist in making the distinction.

#### *a) Prioritization*

In addition to the determination of the applicable governance document to address an identified issue, a set of criteria is required to ensure each issue is brought forward in a consistent and transparent manner. Topic requests are also analyzed with respect to risk and organizational priority.

Early consideration is given to what is required for implementing and maintaining the document over the longer term so that sustainable outcomes (benefits) are achieved. The policy representative undertakes benchmarking and environmental scans to ensure compliance, consistency, and alignment with relevant internal and external influences.

Other relevant partners may be involved in the analysis and prioritization processes, such as the Provincial Operations Group, the Health Technology Assessment Department, and the Patient Safety Department.

#### *b) Identification of Sponsor(s)*

The sponsor(s) acts as the primary content expert for the life of the document in recognition for their expertise and responsibility for the subject matter addressed in the document. Dependent upon the type (or level) of document, it may be appropriate for more than one department to act as a sponsor. Once identified, the sponsor works in collaboration with the policy representative to establish a preliminary plan for development, including identification of working group members to develop the document, potential key stakeholders, expected consultation process, timelines, and possible resource implications.

### *4.2 Development*

Development is a collaborative and iterative activity among the sponsor, the working group, and the policy representative. The sponsor and working group provide content subject expertise to inform the subject content of the document; and the policy representative provides policy expertise to maintain the integrity of the document, ensuring alignment with applicable legislation, bylaws, professional standards, industry standards, and related AHS documents, consistent language, standardized format, and maintaining the processes in accordance with the provisions of the Framework.

### *4.3 Consultation*

Stakeholder consultation is a crucial component in the cycle. This engagement ensures that broad organizational issues related to the governance document are identified early to minimize anticipated operational risks or problems associated with implementation. Stakeholder consultation also assists in achieving acceptance and compliance with the governance document once implemented.



#### *a) External consultation*

External consultation may be required to seek input on the proposed contents of a draft governance document, as well as to develop implementation strategies from professional bodies such as the College of Physicians and Surgeons of Alberta, the Canadian Medical Protective Association, the College & Association of Registered Nurses of Alberta. Comments may be sought from patients and families, external organizations, or members of the public depending on the topic and relevance to the nature of the document. Depending on the subject matter, external legal counsel may be sought as directed by AHS legal counsel.

### *4.4 Endorsement and Approval*

Endorsement is the agreement of the respective leadership teams or committees to support the requirements set out in a governance document, and is guided by the subject matter and type of document. The relevant endorsing bodies are generally indicated by the subject. This may include a departmental senior leadership committee, the provincial operations groups, a medical advisory board, or provincial committee, for example. As a risk management strategy, a review and endorsement by AHS Legal & Privacy is undertaken prior to going forward for approval for:

- bylaws;
- Level 1 and 2 corporate policies;
- selected Level 1 and 2 clinical policies; and
- selected procedures, standards, and protocols.

The approval levels for governance documents are defined in Section 2 *Governance Document Hierarchy and Influences*. A governance document comes into full force and effect upon approval. There may be circumstances, however, where a delay in implementation or a staged implementation is necessary. In such cases, prior to granting approval the approving body must have notification of the delay or staged implementation, including the reasons for the delay. When a delay between approval and implementation occurs, the effective date becomes the date of implementation.

### *4.5 Implementation: Communication, Education, and Practice Change*

Implementation of governance documents includes communication, education, training, and practice change support. It is a complex undertaking that requires commitment, work, and resources. The sponsor is responsible for managing the implementation process. The sponsor undertakes any extended communication and oversees educational and practice change activities identified during the development and consultation stages. Management and department leaders who receive the information regarding new or revised governance documents are



responsible to ensure that others in the department also receive the information. The policy representative participates in the dissemination of the information using a variety of available resources. Governance documents are communicated and published through approved avenues within AHS.

#### 4.6 *Evaluation*

Evaluation is an important component to assess:

- success in achieving the desired outcomes identified during initiation and development; and
- compliance with the requirements.

It is a quality improvement step. At predetermined periods of time following implementation (generally a minimum 3 - 6 months), and immediately prior to the 3-year review period, the sponsor and relevant stakeholders evaluate compliance with the requirements, the appropriateness, efficiency and effectiveness of the document to determine if the issue has been adequately addressed, whether the processes undertaken during the document's development were effective, and whether the desired outcomes have been achieved.

#### 4.7 *Review (periodic and ad hoc)*

The review process provides a regular opportunity for careful consideration of existing governance documents. The periodic review period is as defined for each governance document, or as directed by the appropriate level of authority. Documents are also reviewed on an ad hoc basis when changes occur to practice, legislation, law, industry, or professional standards.

Ongoing feedback on governance documents is encouraged through several venues, including a feedback mechanism embedded in Level 1 and 2 policies. The policy representative maintains a tracking system for periodic reviews and sends notification to the sponsor regarding the need for review for continued applicability or to address change. The sponsor and relevant stakeholders participate in the review to ensure the document remains relevant, current, and supports compliance.

Where gaps or deficiencies are identified during the periodic (or ad hoc) review process, the document is revised following the processes used in the original creation. The review acts as a link forward to the first phase of the cycle, if applicable. Any amendment to an approved governance document requires the same level of approval as the preceding document.

## Contacts

For further information regarding:

- **Clinical policies**, procedures, and clinical practice support documents, contact the Clinical Policy Department: [clinicalpolicy@albertahealthservices.ca](mailto:clinicalpolicy@albertahealthservices.ca), or visit the Clinical Policy webpage on InSite at: <http://insite.albertahealthservices.ca/1493.asp>
- **Corporate policies**, procedures, and corporate practice support documents, contact the Corporate Policy Department at [corporatpolicy@albertahealthservices.ca](mailto:corporatpolicy@albertahealthservices.ca), or visit the Corporate Policy webpage on InSite at: <http://insite.albertahealthservices.ca/corporate-policies.asp>
- **Code of Conduct**, contact the Ethics and Compliance Officer at [complianceofficer@albertahealthservices.ca](mailto:complianceofficer@albertahealthservices.ca), or review the Code at: <http://www.albertahealthservices.ca/pub-code-of-conduct.pdf>
- **Corporate bylaws**, visit the Bylaws webpage at: <http://insite.albertahealthservices.ca/893.asp>
- **Professional Staff bylaws** – medical staff – visit the Bylaws webpage at: <http://www.albertahealthservices.ca/hp/if-hp-phys-bylaws-feb-11.pdf> for midwifery bylaws – contact Health Professions Strategy and Practice.

**AHS Governance Documents – Overview of Accountabilities and Responsibilities (including participation for key groups)**

	AHS Accountability	Responsibility: Initiation	Responsibility: Development	Responsibility: Consultation	Responsibility: Endorsement	Responsibility: Approval	Responsibility: Implementation	Responsibility: Evaluation	Responsibility: Periodic Review
<b>Bylaw (Corporate)</b>	Board	Legislation/ Minister	Board office Portfolio Legal Policy Working Group	Board office Policy Stakeholders	Board Executive Committee Legal	Minister	Board office Portfolio EVP	Board Board office Portfolio Legal Policy	Board Board office Portfolio EVP Legal Policy
<b>Bylaw (Professional)</b>	Board	Legislation/ Minister	Portfolio EVP Legal Policy Working Group	Portfolio EVP Policy Stakeholders	Board Executive Committee Portfolio EVP Legal Stakeholders	Minister	Board office Portfolio EVP	Board Portfolio EVP Legal Policy	Board Portfolio EVP Legal Policy
<b>Principle Statements</b>	Board	Board	Senior Executive Portfolio EVP(s) Policy	Portfolio EVP Policy Stakeholders	Executive Committee	AHS Board	Portfolio EVP(s)	Portfolio EVP Policy Stakeholders	Portfolio EVP Policy
<b>Code of Conduct</b>	Board	Board	Senior Executive Ethics & Compliance Officer Legal Policy	Ethics & Compliance Officer Policy Stakeholders	Executive Committee	AHS Board	Senior Executive Division SVP Ethics & Compliance Officer Policy	Senior Executive; Ethics & Compliance Officer; Legal; Policy	Senior Executive Ethics & Compliance Officer Legal Policy
<b>Directive</b>	Senior Executive	Sponsor Policy	Sponsor Policy Working Group	Sponsor Legal Policy Stakeholders	Sponsor Policy	Executive Committee	Sponsor Policy Stakeholders	Sponsor Policy	Sponsor Policy
<b>Level 1 Policy</b>	Board or Senior Executive	Sponsor Policy	Sponsor Policy Working Group	Sponsor Legal Policy Stakeholders	Sponsor Policy	AHS Board or Executive Committee	Sponsor Policy Stakeholders	Sponsor Policy	Sponsor Policy
<b>Level 2 Policy</b>	EVP	Sponsor: SVP Policy	Sponsor Policy Working Group	Sponsor Legal Policy Stakeholders	Sponsor Policy	EVP	Sponsor Policy Stakeholders	Sponsor Policy	Sponsor Policy
<b>Level 3 Policy</b>	SVP	Sponsor: VP	Sponsor Working Group	Sponsor Stakeholders	Sponsor	SVP (or designate)	Sponsor	Sponsor	Sponsor
<b>Procedure</b>	Same as parent document	Same as parent document	Same as parent document	Same as parent document	Same as parent document	Same as parent document	Same as parent document	Same as parent document	Same as parent document
<b>Practice Support Documents</b>	VP	Sponsor	Sponsor Working Group	Sponsor Stakeholders	Sponsor	VP	Sponsor	Sponsor Stakeholders	Sponsor Stakeholders

Note: This is a general overview. Specific accountabilities and responsibilities may vary.  
 Policy = Clinical Policy Department or Corporate Policy Department, depending on the subject.  
 SVP and VP– where as SVP or VP position does not exist, the next highest level of authority, e.g., Executive Director, Senior Leader, Director