Organizing a Quality and Patient Safety Department in a Hospital

A Guide for Hospital Leaders

ABOUT THIS DOCUMENT

This guide is intended for hospital executives, board members, and senior clinical leaders who are establishing a new Quality and Patient Safety program or reviewing an existing one. It provides an overview of the most widely used organizational models for structuring a Quality and Patient Safety (QPS) department, together with illustrative organograms and practical guidance to support informed decision-making.

A well-structured Quality and Patient Safety department is one of the most important investments a hospital can make. The right organizational model — matched to your hospital's size, culture, governance environment, and strategic priorities — can be the difference between quality improvement that is sustained and embedded, and quality improvement that remains a compliance exercise on paper.

This document does not advocate for a single "correct" model. Instead, it presents the full spectrum of approaches in use globally, with honest commentary on the strengths and limitations of each, so that leaders can make a contextually informed choice.

WHY ORGANIZATIONAL STRUCTURE MATTERS FOR QUALITY

The way a Quality and Patient Safety function is structured sends a signal to the entire organization about how seriously quality is taken. Structure determines:

- Where accountability sits - who is ultimately responsible for quality outcomes and patient safety
- How quality interfaces with clinical work - whether improvement is seen as a "head office" activity or a frontline responsibility
- How resources are allocated - whether dedicated staff and funding are committed to quality or shared across competing priorities
- How quickly the organization can respond - to adverse events, emerging risks, or new accreditation requirements
- Whether quality improvement is sustained - or dependent on the enthusiasm of a few individuals

Getting the structure right from the outset - or correcting a structure that is no longer fit for purpose — is one of the highest-leverage decisions hospital leaders can make.

Key Considerations Before Choosing a Model

Before selecting an organizational model, leaders should reflect on the following questions:

- What is the size and complexity of our hospital? Larger, multi-site, or academic hospitals typically require more formal and dedicated structures than smaller community hospitals.
- What is our governance culture? Is decision-making centralized at the executive level, or is there strong departmental autonomy? The structure should complement - not contradict - the prevailing governance culture.
- What regulatory and accreditation requirements apply to us? Some accreditation bodies (e.g., Joint Commission International, national health authorities) have specific requirements about quality governance structures that must be reflected in the department design.
- What is our current quality maturity? Hospitals in the early stages of building a quality program may need a different structure than those with established systems and a strong safety culture.
- What resources do we have available? The ideal model should be feasible within the organization's actual human resources and financial constraints, while remaining ambitious enough to drive meaningful improvement.
- How do we want quality to relate to clinical leadership? The extent to which physicians, nurses, and allied health professionals are embedded in quality governance is one of the most consequential design decisions.

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THE FIVE ORGANIZATIONAL MODELS

The following section describes five widely used models for organizing a hospital Quality and Patient Safety department. Each model is explained, followed by an illustrative organogram showing how roles and reporting lines may be structured.

MODEL 1: CENTRALIZED/STANDALONE DEPARTMENT

OVERVIEW

This is the most traditional approach. All Quality and Patient Safety functions - including quality improvement, patient safety, risk management, infection control, accreditation, and patient experience - are consolidated within a single, dedicated department. The department reports directly to the Chief Executive Officer (CEO) or Chief Medical Officer (CMO) and has clear institutional authority.

Best Suited For: Large tertiary hospitals, academic medical centers, and hospitals with complex, high-volume quality and accreditation obligations.

KEY STRENGTHS:

- Clear lines of accountability and authority for quality across the organization
- Strong institutional visibility - quality is positioned as a strategic priority
- Consistent standards, tools, and processes applied across all departments
- Easier to coordinate accreditation, regulatory reporting, and organization-wide improvement initiatives

KEY RISKS:

- Risk of becoming siloed from clinical operations
- Frontline staff may perceive quality as a "head office" function rather than their own responsibility
- Centralized teams can become overwhelmed if they are the sole owners of improvement work across a large organization



MODEL 2: INTEGRATED/EMBEDDED MODEL

OVERVIEW

In this model, quality and safety roles are embedded directly within clinical departments or service lines rather than sitting in a separate central department. Each department or division has a dedicated Quality Lead or Safety Officer who is accountable to their departmental head for day-to-day activities, and to a central quality coordinator for standards, reporting, and methodology. The central team is small and functions more as a facilitator and standard-setter than an operational unit.

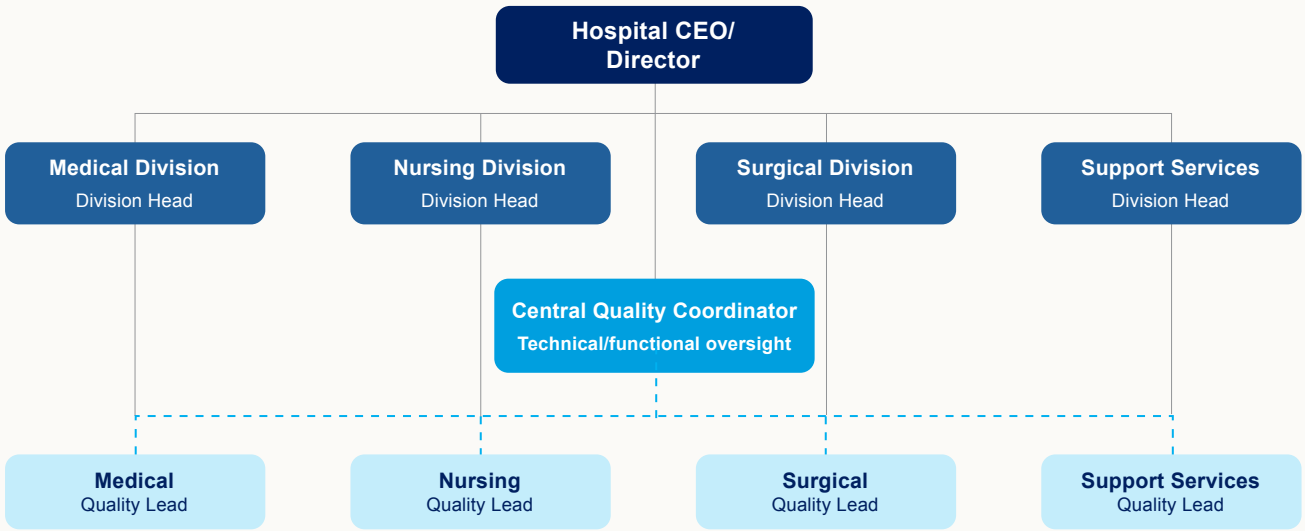
Best Suited For: Hospitals with strong departmental autonomy, those implementing a service-line management model, or organizations that have found centralized models insufficiently connected to clinical realities.

KEY STRENGTHS:

- Quality improvement is owned by those delivering care — significantly increasing relevance and buy-in
- Closer integration between quality activities and clinical workflows
- Faster identification and response to quality issues at the point of care

KEY RISKS:

- Risk of significant inconsistency in standards, data, and approaches across departments
- Central oversight and coordination can be difficult to maintain
- Quality Leads may feel isolated without a strong community of practice or central support structure



Solid line: Operational reporting (Division Head)
Dotted line: Technical/functional oversight (CQC)

MODEL 3: MATRIX MODEL

OVERVIEW

The matrix model is a hybrid of the centralized and embedded approaches and is among the most widely adopted models in mid-to-large hospitals today. A central Quality and Patient Safety Department sets standards, provides tools and training, manages accreditation, and ensures compliance. Meanwhile, Quality Champions or Improvement Leads embedded in each clinical division report along two lines: to their divisional head for operational matters, and to the central department for quality and safety performance.

This model is also highly compatible with a Quality Champions Programme (see companion document: Quality Champion Role Description Template), where staff volunteers serve as quality advocates within their departments while receiving support and direction from the central QPS team.

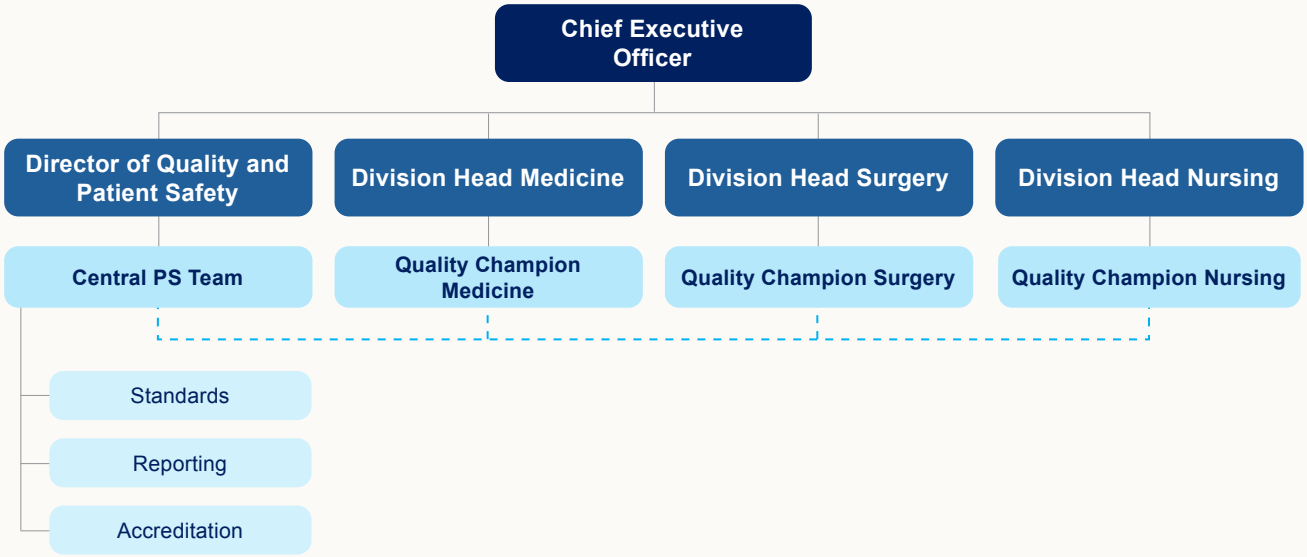
Best Suited For: Medium to large hospitals seeking both central coordination and departmental ownership of quality.

KEY STRENGTHS:

- Balances the consistency and authority of a centralized model with the clinical ownership of an embedded model
- Prevents quality from being entirely peripheral to clinical operations
- Supports the development of a broad quality improvement workforce across the organization

KEY RISKS:

- Dual reporting lines can create ambiguity about authority and accountability
- Requires careful role design and clear communication to avoid confusion
- Success depends heavily on a strong, well-resourced central team and skilled divisional Quality Champions



Dotted line: Central QPS Team has functional authority over Quality Champions
Solid line: Division Heads have operational authority over Quality Champions

MODEL 4: QUALITY COUNCIL/COMMITTEE-LED MODEL

OVERVIEW

Rather than establishing a permanent operational department, quality governance in this model is led by a multidisciplinary Quality Council or Committee — typically chaired by the CMO or CEO — that meets regularly to review performance data, set improvement priorities, and commission and oversee improvement work. A small secretariat supports the council administratively. This model is governance-focused rather than operationally focused.

Best Suited For: Smaller hospitals, district hospitals, or hospitals in the early stages of building a quality program with limited resources for a dedicated QPS department.

KEY STRENGTHS:

- Engages broad leadership — including physicians, nurses, administrators, and patient representatives — in shared ownership of quality
- Relatively low resource requirement compared to a dedicated department
- Promotes a culture where quality is seen as everyone's responsibility, not a specialist function

KEY RISKS:

- May lack the operational capacity to drive day-to-day improvement work between council meetings
- Dependent on the engagement, regularity, and effectiveness of the committee
- Risk of quality governance becoming a "meeting exercise" without sufficient follow-through on decisions



MODEL 5: DYAD LEADERSHIP MODEL

OVERVIEW

An increasingly popular model in which quality and safety leadership is shared between a physician leader (e.g., Chief Quality Officer or Medical Director of Quality) and a nursing or administrative leader (e.g., Director of Quality and Safety), who co-lead the department as equal partners with complementary expertise. This dyad leadership arrangement is then mirrored at the divisional level, with clinical-administrative pairs jointly accountable for quality within their service area.

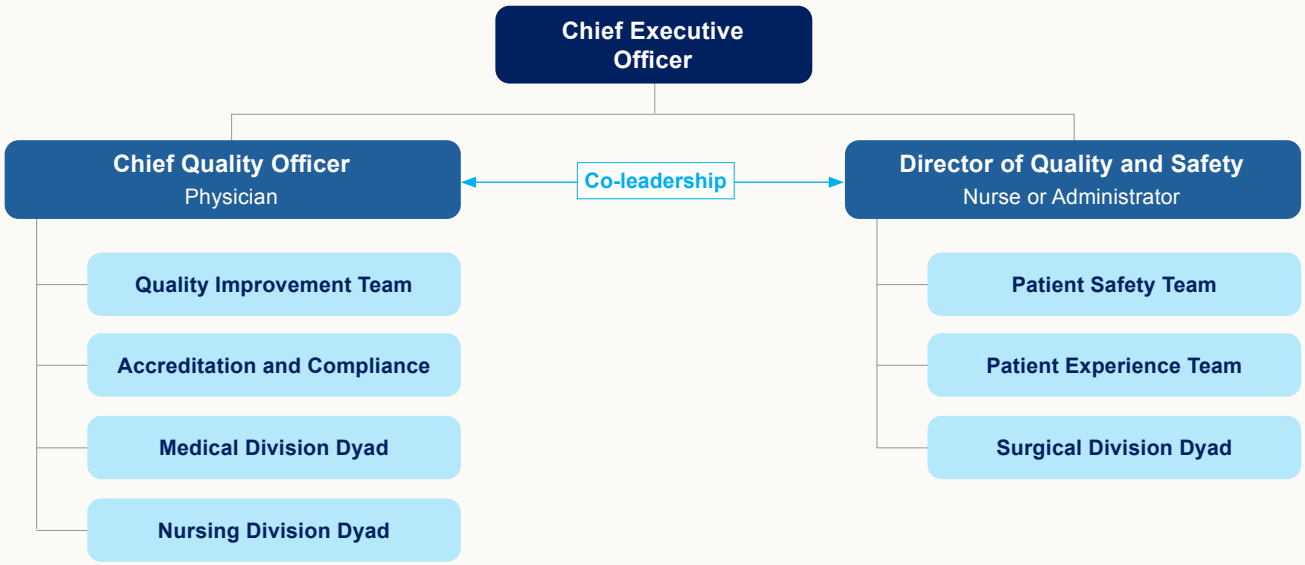
Best Suited For: Hospitals of all sizes that prioritise strong clinical engagement in quality leadership and seek to reduce the traditional divide between clinical and administrative quality functions.

KEY STRENGTHS:

- Bridges clinical credibility with operational management expertise
- Promotes interdisciplinary collaboration at all levels of the quality structure
- Physician co-leadership significantly increases peer influence over clinical quality improvement
- Reduces the perception that quality is an administrative imposition on clinical practice

KEY RISKS:

- Requires a strong, trust-based working relationship and very clear role delineation between dyad partners
- Risk of duplication, confusion, or conflict if roles overlap without clear boundaries
- May be challenging to recruit qualified physician leaders willing to take on a significant quality leadership role alongside clinical duties



CHOOSING THE RIGHT MODEL: A COMPARATIVE SUMMARY

MODEL	BEST FOR	KEY STRENGTH	KEY RISK
Centralized/Standalone	Large and complex hospitals	Clear accountability and institutional authority	Risk of siloing from clinical work
Integrated/Embedded	Service-line organizations with strong departmental autonomy	Deep clinical ownership of quality	Inconsistency across departments
Matrix	Medium to large hospitals seeking balance	Combines central coordination with frontline ownership	Dual accountability can create confusion
Quality Council/ Committee	Smaller hospitals, early-stage programs	Broad leadership engagement, low resource requirement	Limited operational capacity between meetings
Dyad Leadership	All sizes; clinical engagement is a priority	Clinical-administrative collaboration at all levels	Role ambiguity between dyad partners

PRACTICAL RECOMMENDATIONS FOR HOSPITAL LEADERS

Start with governance clarity. Regardless of which model you choose, the most important first step is to clearly define who is accountable for quality outcomes at the board, executive, and departmental levels. Ambiguity in accountability is the single greatest risk to any quality program.

Match structure to maturity. Hospitals in the early stages of building a quality program should not attempt to implement the most complex model from the outset. A well-functioning Quality Council with a small secretariat may be more effective than a large, under-resourced centralized department.

Invest in people, not just structure. An organogram is only as effective as the people within it. Invest in the training, development, and empowerment of Quality Champions, Quality Leads, and QPS department staff. Consider developing a formal Quality Champions Programme to build improvement capacity across the organization.

Build in clinical co-leadership from the start. The evidence is clear that quality improvement efforts are more likely to succeed and be sustained when physicians and nurses are meaningfully involved in leadership — not just as consultants, but as co-owners of the quality agenda.

Plan for evolution. The right structure today may not be the right structure in three to five years. Build in regular reviews of your quality department's structure as the program matures and as the organization's needs change.

Align structure with accreditation requirements. If your hospital is seeking or maintaining accreditation from a national or international body, ensure that your quality governance structure meets their specific requirements before finalizing your model.

Conclusion

Establishing an effective Quality and Patient Safety department is one of the most consequential decisions hospital leaders will make. The organizational model chosen will shape the culture of quality across the institution, determine the speed and sustainability of improvement, and signal — loudly and clearly — how much the organization truly values safe, high-quality patient care.

The models described in this guide each have genuine merit and real-world evidence behind them. The best choice is not the most sophisticated model, but the one most honestly matched to your hospital's context, resources, and ambitions — and implemented with the leadership commitment and resourcing it requires.

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