

Quality & Safety at PHSA

An Integrated Strategy

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Thank You

A heartfelt thank you to everyone who has been involved in the Integrated Quality & Safety Strategy.

From its initial development to ongoing implementation, countless individuals have played a vital role in driving this work forward including the PHSA Indigenous Health Team, the Risk Management Team, the Data Analytics Reporting & Evaluation Team, Operational and Medical Leaders, Patient Partners, the PHSA Executive Leadership Team, and the PHSA Quality & Safety Board Committee. We are especially grateful to the Quality & Safety Team and the Patient & Family Partnerships & Experience Team for their leadership and dedication championing much of the work highlighted throughout this document.



PHSA’s Quality, Patient Safety & Experience Leadership Team

Land Acknowledgement

PHSA provides specialized health care services to communities across British Columbia, on the territories of many distinct First Nations. We are grateful to all the First Nations who have cared for and nurtured the lands and waters around us for all time, including the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish Nation) and səlílwətał (Tsleil-waututh Nation) on whose unceded and ancestral territory our head office is located.

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Coast Salish Teachings

The Coast Salish Teachings have been gifted to PHSA by Knowledge Keeper, Sulksun, Shane Pointe. These teachings guide our work as we seek to improve quality and safety across PHSA. They allow us to open ourselves up to a rich and eternal worldview and provide new wisdom to address longstanding issues.



Thee eat
"Truth"



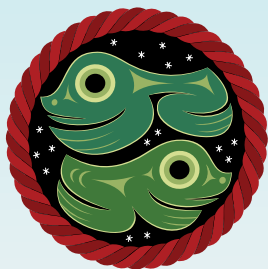
Eyhh slaxin
"Good medicine"



Nuts a maht
"We are one"



**Whax hooks
in shqwalowin**
"Open your hearts
and your minds"



**Kwum kwum
stun shqwalowin**
"Make up your mind
to be strong"



Tee ma thit
"Do your best"

*With thanks to Sulksun
and artist Atheana Picha*



Sulksun gifting the Coast Salish Teachings to the PHSA Quality & Safety Team.

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PHSA continually works to provide safer and higher quality care to our patients. The Integrated Quality & Safety Strategy is our guide for advancing a coordinated approach across the organization. It provides a systems approach that brings together the core principles of quality and safety, the unique role of PHSA programs and services, and the diversity of people across the health system. These common goals and direction provide everyone with a clear line of sight to how their work impacts and contributes to the goals of the organization.

The Integrated Quality & Safety Strategy is a commitment shared by all to ensure PHSA is a quality driven, safety focused and person*-centered organization.

Throughout the strategy, **person refers to patients, families, caregivers and communities.*

We need to continue our focus on quality and safety because, in Canada:



Indigenous-specific racism and discrimination is a **major problem** in the health care system¹



Every **1 minute and 18 seconds** there is a patient safety event²



One of every eighteen hospitalized patients experience a preventable incidence of harm³

\$2.75 B

These events cost the health care system an additional **\$2.75 billion** per year²



Patient safety incidents are the **3rd highest cause of mortality**^{2, 4}

At PHSA, the results from the most recent Engagement Survey and the Patient Safety Culture Survey in 2021–2022 also clearly indicated that attention was required:

59% rated the overall perception of patient safety culture as positive

40% worried that if they made a serious error, they would face disciplinary action

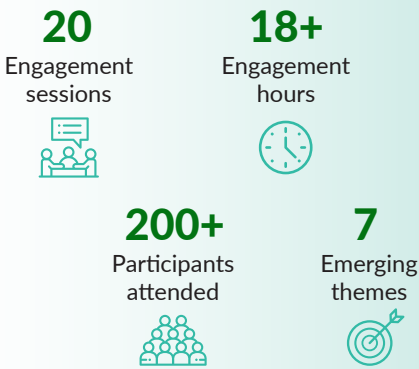
33% worried that making a serious error would limit their career opportunities at PHSA

% ↓ The percentage of favourable responses to both “Senior managers are committed to providing a safe and healthy workforce” and “Senior managers are committed to providing high quality care” **decreased** from the last survey in 2018.

Developing the Strategy

In the Spring of 2022, work began to develop an Integrated Quality & Safety Strategy to align PHSA’s clinical service delivery programs with clear purpose, goals, objectives and priority work to improve the quality and safety of care provided by our services. It is essential that this strategy speaks to those who access our services and those who work in our organization. This robust engagement took place with over 200 participants sharing their unique perspectives and ideas including medical staff and patient partners.

We’ve also drawn inspiration from leading organizations, including the Institute for Healthcare Improvement’s Integrated Approach to Whole System Quality and Canada’s Patient Safety Framework for Health Services, as well as an external review of PHSA’s Quality & Safety Program that recommended we refine our governance and structures to meet the evolving landscape of health care delivery.



What we heard

“ Incorporate co-design and co-decision making at all levels to ensure meaningful involvement with patient, families and caregivers.”

“ Integrate Indigenous ways of knowing and being within the strategy and within the quality and safety work we do.”

“ Partner with other departments at PHSA to drive the strategy’s sustainability and evaluation.”

“ Involve clinical service areas in implementing quality improvement projects to inspire staff and build capacity.”

“ Provide the flexibility for programs to lead quality improvement while aligning their work with the integrated strategy.”

“ Recognize and address health human resource constraints.”

“ Focus on establishing a just, anti-racist, psychologically safe, and culturally safe culture.”

How we incorporated the feedback

Based on this feedback, we refined the strategy goals, objectives, and priority projects. The strategy was presented to the PHSA Executive Leadership Team, the PHSA Health Authority Medical Advisory Committee, and the Quality & Safety Board Committee for endorsement in Fall 2022. Engagement has continued since the launch of the strategy to learn what is working well, where there are opportunities for improvement, and identify future areas of focus.

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The review and engagement informed the five goals that make up the Integrated Quality & Safety Strategy. These goals are illustrated with interconnected circles, because each goal is connected to one another.

Work in one area of the strategy will impact the other areas, which moves us closer to the overall strategic purpose of advancing PHSA as a quality driven, safety focused and person-centered organization. The strategy describes how we will build on our strengths and support our teams to do work in a different way to better meet the needs of the diverse populations we serve.

The strategy is wrapped in the Provincial Dimensions of Quality from Health Quality BC.⁵ The Staff Wellness and Capability dimension has been added because when our staff and health care providers are well cared for, respected, engaged, and supported to do their best work every day, they deliver higher quality and safer care.

In 2023, Coast Salish Knowledge Keeper, Sulksun, Shane Pointe presented PHSA with his gift of six Coast Salish Teachings. To remind us of our commitment to these teachings and our role to embed them throughout our work, we've updated the visualization of the strategy to show the close connection between this work and each of the teachings.



With thanks to Sulksun and artist Atheana Picha

“ You have gifted us your heart and your teachings. We humbly accept them and will pick them up, making them part of the DNA of PHSA so that employees today, and all those who join us in the future, know what they mean and the accountability they bring.”

– Joe Gallagher, Kwunuhmen, Vice President, Indigenous Health and Cultural Safety

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- Goal 2 Learning Health System
- Goal 3 Culturally Safe and Anti-Racist Environment
- Goal 4 Person-Centered Partnership
- Goal 5 Data-Informed Decision Making



Goal 1 Governance, Accountability and Alignment

Refreshed organization governance and accountability model to ensure alignment and integrated approach to quality and safety priorities and system outcomes.

OBJECTIVES		KEY RESULTS
1	Set a clear direction on a shared purpose and strategy for achieving organizational excellence inclusive of quality and safety.	There is a PHSA-wide Integrated Quality & Safety Strategy, including a roadmap of priority work.
2	Governance, accountability, and organization structures within and across clinical service delivery programs at PHSA enable an effective integrated strategy.	A new framework for governance and accountability for quality and safety has been activated.
3	Clear directions, goals and priorities cascade across and within programs.	All staff are clear on how their work relates to priorities of the organization.



Camille Ciarniello, Risk Director, and Quality & Safety Team Members Rutendo Chitungo and Natasha Rakocija.

Project Highlight

Establish a PHSA Integrated Quality & Safety Steering Committee

The Integrated Quality & Safety Steering Committee was established in 2024 to ensure an aligned and integrated approach to quality and safety at PHSA. This committee brings together leaders across the organization to set priorities, enable alignment, remove barriers, and incorporate Indigenous ways of knowing and being across all quality and safety work. A key priority of this work is to incorporate the patient voice in a meaningful and robust way. The first meeting took place in June 2024 and the committee continues to meet bi-monthly. Efforts are underway to develop an evaluation plan to facilitate continuous improvement.

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Goal 1 Governance, Accountability and Alignment

Refreshed organization governance and accountability model to ensure alignment and integrated approach to quality and safety priorities and system outcomes.

ACTIVITIES TO ACHIEVE GOAL 1

OKR	PROJECTS	OKR = Objectives and Key Results	STATUS
1	Developed Integrated Quality & Safety Strategy and roadmap of priority work.		✓
	Determine Integrated Quality & Safety Strategy impact measures.		●
2	Reviewed Quality & Safety Committee structures across PHSA programs.		✓
	Updated and aligned program Quality & Safety Committee terms of reference.		✓
	Established PHSA Integrated Quality & Safety Committee.		✓
	Determined program Quality & Safety Director reporting relationships.		✓
	Prepared integrated organizational charts for operational Quality & Safety and Medical Leadership within each program.		✓
	Propose future state of operational Quality & Safety and Medical Leadership dyad model at PHSA.		●
	Explore forming a centralized critical patient safety event review team.		●
3	Expand quality and safety structure to include Health Improvement Networks and Provincial Care Programs.		●
	Reviewed and aligned roles and responsibilities for Quality & Safety Team members.		✓
	Establish strategy deployment (catchball) for priority setting within programs.		●

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Goal 2 Learning Health System

Adoption of best and wise approaches enabling continuous quality improvement, quality assurance and safety practices.

OBJECTIVES		KEY RESULTS
1	Consistent application of tools, processes, and practices to do quality and safety work.	Best and wise practices for quality and safety are aligned and consistently in use across the organization.
2	PHSA is a learning health system that integrates learnings to continuously improve care for all patients.	Staff* are engaged and actively participate in a learning health system which shares learnings from safety events and implements timely system-focused improvements.
3	Engage, educate and support our staff* to contribute meaningfully to continuous quality improvement and safety work.	Staff* have the capability, capacity and structures required to lead quality and safety work.
4	Integrate Indigenous ways of knowing, doing and being into our learning and improvement work.	Indigenous ways of knowing, doing and being are integrated in quality and safety work.

**Staff refers to all PHSA employees and medical staff.*

Project Highlight

Patient Safety Policy

Over the years, PHSA has developed policies and procedures to provide guidance and standards covering key areas of safe care. This project consolidated four existing policies into a single, comprehensive Patient Safety Policy. Updates were also made to strengthen the policy’s focus on anti-racism, diversity, equity, inclusion, eradicating Indigenous-specific racism and discrimination, and recognizing the pivotal role that patients and families play in safety. The new policy was published in September 2023 and is reviewed and updated annually.



Rachel Li, Risk Management Specialist, and Quality & Safety Team Members Marketa Panagos and Alina Rakhmanova

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ACTIVITIES TO ACHIEVE GOAL 2

OKR	PROJECTS	OKR = Objectives and Key Results	STATUS
1	Created a Patient Safety Policy to streamline information from five existing policies.		✓
	Developed an efficient and aligned patient safety event review process.		✓
	Developed an early notification process for potential critical events.		✓
	Developed a Serious Adverse Drug Reactions Procedure.		✓
	Developed a Medical Device Incident Procedure.		✓
	Refreshed PHSA's accreditation approach to assess some standards system-wide before the sequenced on-site surveys.		✓
	Develop the Speak Up for Patient Safety Procedure.		●
	Expand the Speak Up for Patient Safety Procedure to include activation by patients and families.		●
	Develop and align an efficient patient safety event review process for multi-Health Authority reviews.		●
	Develop a low and no harm patient safety event management protocol.		●
2	Initiated Quality & Safety Walkabouts in which Executive Leadership Team members visit sites to speak with staff, patients and families.		✓
	Hosted an expert panel to review a U.S. case study on the criminalization of a medical error, followed by staff huddles.		✓
	Piloted the Continuous Improvement Learning Community of Practice at BC Emergency Health Services.		✓
	Implemented learning summaries to share lessons learned from patient safety event reviews.		✓
	Expand the Continuous Improvement Learning Community of Practice to other Program Areas.		●
	Implement an Institute for Healthcare Improvement 'Break the Rules' Pilot.		●
3	Coordinated a disclosure education strategy for care providers and implemented key updates to the curriculum.		✓
	Develop orientation and onboarding process and materials for Quality Safety Leaders.		●
	Create a PHSA quality improvement education framework.		●
	Define Patient Safety Event Review Chair roles and responsibilities.		●
	Establish a Quality Improvement Hub for intaking, supporting and tracking quality improvement projects and learnings across PHSA.		●
4	Incorporate Indigenous ways of knowing and being into quality and safety work.		●

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Goal 2 Learning Health System

Adoption of best and wise approaches enabling continuous quality improvement, quality assurance and safety practices.

Project Highlight

Patient Safety Event Reviews

Patient safety event reviews are a critical mechanism for identifying system gaps and implementing improvements to prevent similar incidents in the future. While these reviews were already in place at PHSA, the approach varied across programs. In June 2022, the team started a comprehensive current-state analysis to understand existing processes and design an aligned approach with the goals of reducing variation and increasing efficiency. Following extensive engagement with key partners, the revised protocol and new support tools were published in 2024. Key changes included revised review completion timelines, stronger emphasis on follow-through and sharing learnings, enhanced accountability for recommendation implementation, and improved participation of Indigenous Health and Diversity, Equity and Inclusion teams, as appropriate. Throughout that summer, workshops equipped Quality & Safety Teams with the knowledge to implement the updated process effectively. This was followed by education to program leadership, including operational and medical leadership, that outlined the key changes to the process and highlighted their role in this important work. Given the scope of these changes, evaluation of the protocol and tools is underway to identify opportunities for improvement.



BC Women's Hospital, CARE Program Quality & Safety Walkabout in July 2024 with David Byres, President and CEO, and Dr. Jana Davidson, Chief Medical Officer.

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Goal 3 Culturally Safe and Anti-Racist Environment

Establish a just, inclusive, anti-racist, psychologically and culturally safe environment for all people (staff, providers, patients and families) in all areas at PHSA.

OBJECTIVES		KEY RESULTS
1	Address and eliminate racism for all people at PHSA and cultivate a respectful, safe and inclusive environment.	Health outcomes stratified by race are measured, actively monitored and used to make improvements where needed.
2	Address and eliminate Indigenous-specific racism and hard-wire Indigenous cultural safety and humility.	A cultural safety and anti-racism learning standard for PHSA staff and providers has been embedded in the organization.
3	Develop transformational leaders that are curious and responsive to foster an equitable and just culture.	Leadership is responsive to issues of racism, diversity, equity and inclusion and as a result, staff and patients report a safer environment.

Project Highlights

Indigenous Identification Mechanism in the Patient Safety and Learning System

Prior to this project, the Patient Safety and Learning System lacked the functionality to capture whether a patient has self-identified as Indigenous. Integrating this capability has enabled timely awareness of patient safety events that involve Indigenous patients and clients. This improvement has strengthened the Indigenous Health Team’s ability to provide immediate support and for the program to assess if these events involved Indigenous-specific racism and discrimination.



Develop a Process for Reviewing Indigenous-Specific Racism and Discrimination

The pre-existing critical patient safety event review process was not designed to investigate Indigenous-specific racism and discrimination (ISRD) in a way that met the needs of Indigenous patients and families. This project established a new review process that is culturally safe, distinctions-based, and trauma- and violence-informed. Grounded in principles of reconciliation, transparency and systemic change, these reviews ensure a more person-centered approach. To achieve this goal, a new committee, the PHSA Thee Eat and ISRD Response Committee was established and began intaking incidents of Indigenous-specific racism and discrimination in July 2023. The process evolved as the Committee and programs refined their approach to these cases, leading to the publication of a protocol in early 2025.



Goal 3 Culturally Safe and Anti-Racist Environment

Establish a just, inclusive, anti-racist, psychologically and culturally safe environment for all people (staff, providers, patients and families) in all areas at PHSA.

ACTIVITIES TO ACHIEVE GOAL 3

OKR	PROJECTS	OKR = Objectives and Key Results	STATUS
1	Implemented an Indigenous identification mechanism in the Patient Safety and Learning System.		✓
	Launch a new enhanced review module in the Patient Safety and Learning System for racism and discrimination reviews.		●
	Determine, measure and report appropriate quality care metrics on health outcomes by race, starting with Indigenous-specific stratification.		●
	Develop the systems and processes to gather race identification of our patients.		●
	Partner to do quality improvement work to make improvements where there are inequities with quality outcomes.		●
2	Established a Thee Eat and Indigenous-Specific Racism and Discrimination Response Committee.		✓
	Developed a process for reviewing Indigenous-specific racism and discrimination that caused patient or family harm.		✓
	Develop a standard for the tracking and trending of no and low harm patient safety events that involve Indigenous patients.		●
	Embed and Educate Staff on Cultural Safety and Humility Health Standards Organization Standard.		●
3	Determined racism reviews not appropriate for Section 51 protection.		✓
	Develop and implement a mechanism to report racism and discrimination as a cause of harm in the Patient Safety and Learning System.		●
	Prepare an Indigenous-led Resolution Guide.		●
	Develop and Implement organization-wide reporting and responding to harm from Indigenous-specific racism and discrimination education strategy.		●
	Develop and implement a process to report and review psychological harm to patients and families resulting from patient safety events.		●

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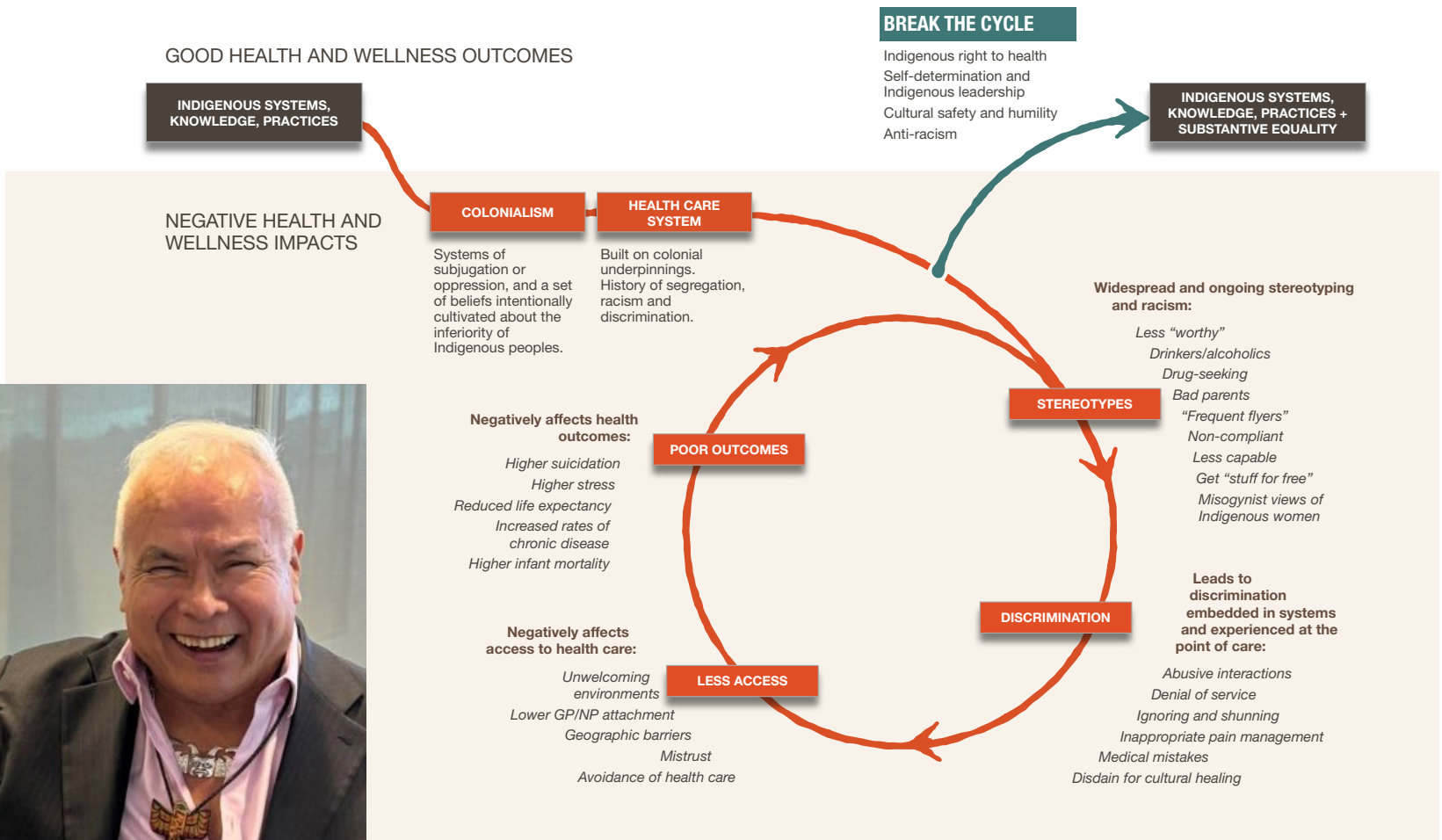


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Establish a just, inclusive, anti-racist, psychologically and culturally safe environment for all people (staff, providers, patients and families) in all areas at PHSA.



Elder Xwechtaal Dennis Joseph at the Cultural Safety and Humility HSO Standard Workshop in November 2024.



Break the Cycle Graphic from the [In Plain Sight Report](#) (page 19)

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Goal 4 Person-Centered Partnership

Create meaningful engagement opportunities with patients, families and caregivers to support collaboration, build trust throughout their care journey and include their voices in system improvements.

OBJECTIVES		KEY RESULTS
1	Implement initiatives and best practices that promote people-centered care and improve patient experience at the point of care.	People-centered care best practices are utilized across the organization.
2	Enhance the capability and capacity of PHSA staff and providers to lead inclusive, equitable and culturally safe patient and family engagement.	Staff can confidently engage patients and families with the available guidance, tools, and supports.
3	Build and nurture mutually beneficial partnerships that foster collaboration, continuous improvement, and shared learnings in people-centered care and engagement.	Strong relationships have been formed across PHSA and with external organizations that are invested in advancing people-centered care and meaningful engagement.



PHSA Patient and Family Engagement Framework

Project Highlight

PHSA Patient and Family Engagement Framework & Recognition and Honorarium Playbook

To reinforce PHSA's commitment to patient-centered care, we have developed a Patient and Family Engagement Framework that provides practical guidance for engaging patients and families in our programs, services, research and health system initiatives. This framework outlines key principles and a structured approach to engagement, supporting staff efforts to ensure that the voices of patients and families can meaningfully shape the care and services we provide. The team has also developed a companion document, Beyond Grateful: A Playbook for Recognition, Honorariums and Expenses for Patient and Family Partners at PHSA, in partnership with PHSA Finance. The Playbook offers guidance and resources on ways to recognize patient and family partners for their contributions and support equitable and accessible participation.

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ACTIVITIES TO ACHIEVE GOAL 4

OKR	PROJECTS	OKR = Objectives and Key Results	STATUS
1	Completed external review with the Institute for Patient and Family-Centered Care at BC Women’s Hospital, BC Children’s Hospital, BC Cancer, and BC Mental Health and Substance Use Services.		✓
	Launch patient and family centered care clinical care campaigns, such as What Matters to You, and Hello My Name Is.		●
	External review with the Institute for Patient and Family-Centered Care for the remaining programs (BC Emergency Health Services and BC Center for Disease Control).		●
	Develop a PHSA Family Presence Policy.		●
	Share quality and safety data with patients and families.		●
2	Developed a patient engagement central hub on POD (internal website).		✓
	Developed a Patient Engagement Framework for PHSA.		✓
	Facilitated a Patient and Family Centered Care Board Retreat.		✓
	Developed a playbook and guidance for recognition, honorariums and expenses for patient and family partners at PHSA.		✓
	Establish patient partner participation in patient safety event reviews.		●
	Develop a toolkit for including patient partners on hiring panels.		●
	Develop patient and family engagement learning series.		●
	Develop a strategy for patient and family partner engagement in policy work.		●
	Update patient engagement central hub on POD with resources.		●
	Develop a PHSA-wide patient partner orientation and onboarding program.		●
	Develop a toolkit to involve patient partners on committees.		●
	Include patient and family partners in staff orientations.		●
	Establish a process to include patient and family partners in quality improvement work.		●
	Implement a hub and spoke model for communicating engagement opportunities.		●
	Update leadership job descriptions to include patient and family centered care competencies.		●
	Hosted a PHSA Patient Experience and Partnerships Symposium.		✓
	Established a Patient and Community Engagement Community of Practice.		✓
3	Established a PHSA Patient Experience and Partnerships Steering Committee.		✓
	Shared patient stories at the Quality & Safety Board Committee.		✓
	Refresh the approach to sharing patient stories at the Quality & Safety Board Committee.		●
	Establish a biennial Patient Experience and Partnerships Symposium.		●
	Establish a PHSA Patient and Family Advisory Council.		●



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Goal 4 Person-Centered Partnership

Create meaningful engagement opportunities with patients, families and caregivers to support collaboration, build trust throughout their care journey and include their voices in system improvements.

Project Highlight

Patient and Family Partner Participation in Patient Safety Event Reviews

Diverse perspectives are essential to uncover root causes and gain a deep understanding of safety events. Patient and family partners offer valuable lived experience and can identify areas for improvement that might otherwise go unnoticed, driving meaningful change and stronger safety solutions. A guide and framework to support the safe and meaningful involvement of patient and family partners in reviews at PHSA is in development. These resources will be piloted in 2025, with broader communication and education in 2026 to spread this best practice across the organization.



Patient & Family Partner Panel at the Patient Experience & Partnerships Symposium in April 2024.



The patient driving the health care rather than just being a partner is a critical element if we're going to advance some of this discussion on quality. It's not just building a conversation around a person. It's that that person has a leadership role in designing their own health and wellness journey."

– Indigenous health care leader (Canadian Quality and Patient Safety Framework)



Goal 5 Data-Informed Decision Making

Data-informed decision making and evaluation that supports quality and safety direction.

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OBJECTIVES		KEY RESULTS
1	Data collected by PHSA is useful for staff and leaders to inform decision making.	There are meaningful indicators that support monitoring and evaluating organizational quality and safety goals.
2	Improve the availability of appropriate quality, safety and patient experience data.	Data is shared within and across programs to support aligned, focused, meaningful and timely quality improvement and evaluation.
3	Monitor performance and drive continuous improvement by using data.	Data is used to inform learning actions related to patient safety and experience.

Project Highlights

Update PHSA Quality Dimensions to Incorporate Cultural Safety and Humility Indicators

Every quarter, Quality & Safety Indicator Reports are prepared which incorporate indicators from all clinical service delivery programs at PHSA. These metrics are categorized into quality dimensions which were adapted from Health Quality BC’s Matrix. In 2020, these dimensions were updated to better integrate cultural safety as a fundamental aspect of safe, high-quality care. This project focused on aligning the existing measures to the updated dimensions of quality and identifying new indicators for the Cultural Safety Dimension. Future work will expand the metrics reported within this dimension.

Develop a PHSA-wide Dashboard to Track and Report on Recommendation Status from Critical Comprehensive Patient Safety Event Reviews

The first annual report on implementation status of recommendations from critical comprehensive patient safety event reviews was presented to the Quality & Safety Board Committee in June 2023. Building on this work, we are developing a dashboard that tracks and reports on these recommendations, enhancing visibility for the Quality & Safety Board Committee, Program Quality & Safety Committees and recommendation owners responsible for advancing the recommendations within their program area. The dashboard is expected to launch by mid-2025, after which efforts will begin to adapt or expand it to include recommendations from Indigenous-specific racism and discrimination reviews.



Goal 5 Data-Informed Decision Making

Data-informed decision making and evaluation that supports quality and safety direction.

ACTIVITIES TO ACHIEVE GOAL 5

OKR	PROJECTS	OKR = Objectives and Key Results	STATUS
1	Updated PHSA Quality Dimensions to incorporate cultural safety and humility indicators.		✓
	Expand the use of cultural safety and humility indicators in the Quality & Safety Indicator Reports across all clinical service delivery program areas.		●
	Implement Health Standards Organization's Global Workforce Survey.		●
	Develop and implement a patient safety culture pulse check survey.		●
	Develop and operationalize PHSA patient experience and cultural safety measurement strategy.		●
2	Developed data sharing mechanism between Patient Care Quality Office and program Quality & Safety Committees.		✓
	Established a process to involve Quality & Safety Team and Medical Leadership in indicator reporting.		✓
	Developed an annual report to track recommendation implementation status from critical comprehensive patient safety event reviews.		✓
	Developed a process to track Indigenous-specific racism and discrimination events and reports.		✓
	Generate a Patient Safety and Learning System dashboard and report for Program Quality & Safety Committee review and Board awareness.		●
	Develop a PHSA-wide dashboard to track and report on recommendation implementation status from critical comprehensive patient safety event reviews.		●
	Develop a bi-annual report on the Indigenous-specific racism and discrimination reviews and recommendation implementation.		●
	Adapt or expand the recommendation implementation status dashboard to include Indigenous-specific racism and discrimination reviews.		●
3	Develop performance boards for use by direct care staff.		●
	Determine a process for Patient Care Quality Office data to inform quality improvement work.		●
	Identify the vital few quality and safety indicators across PHSA.		●
	Define streamlined processes to access clinical data to inform quality improvement work.		●
	Collect, analyze and apply patient reported experience and outcome data to quality improvement work.		●
	Create a Patient Engagement Measurement Strategy.		●

LEGEND — PROJECT STATUS



COMPLETE



IN PROGRESS



NEXT UP



FUTURE PRIORITY

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Measuring Impact

The Integrated Quality & Safety Strategy impacts our organization at multiple different levels. Therefore, the evaluation also requires a multi-modal approach with evaluation at the project, goal and strategy level.

Project-Level:

Each project is evaluated to ensure its intended outcomes are met and identify improvement opportunities for the project team.

Goal-Level:

Each goal is evaluated to determine if the objectives and key results have been met. The key results at this level are bigger than any one project. This evaluation is influenced by strategy projects and other initiatives within the organization.

Strategy-Level:

The overall impact of the strategy is evaluated against two strategy outcomes, **strengthen our culture of quality and safety** and **improve the quality of care**, which are influenced by many different factors. These are the ultimate reasons behind the work and what will allow us to reach our purpose of being a quality driven, safety focused and person-centered organization. To measure progress towards these outcomes data will be analyzed using the HSO Global Workforce Survey, the Patient Safety Culture Survey Pulse Check, the Quality & Safety Indicator Reports, Patient Reported Experience and Outcome Measures, and the Patient Safety and Learning System.



Kathleen Johnson, Sr. Consultant DEI, and Mary MacKillop, Sr. Director, Patient Experience, facilitators of the Inclusive Engagement session at the Patient Experience & Partnerships Symposium in April 2024.

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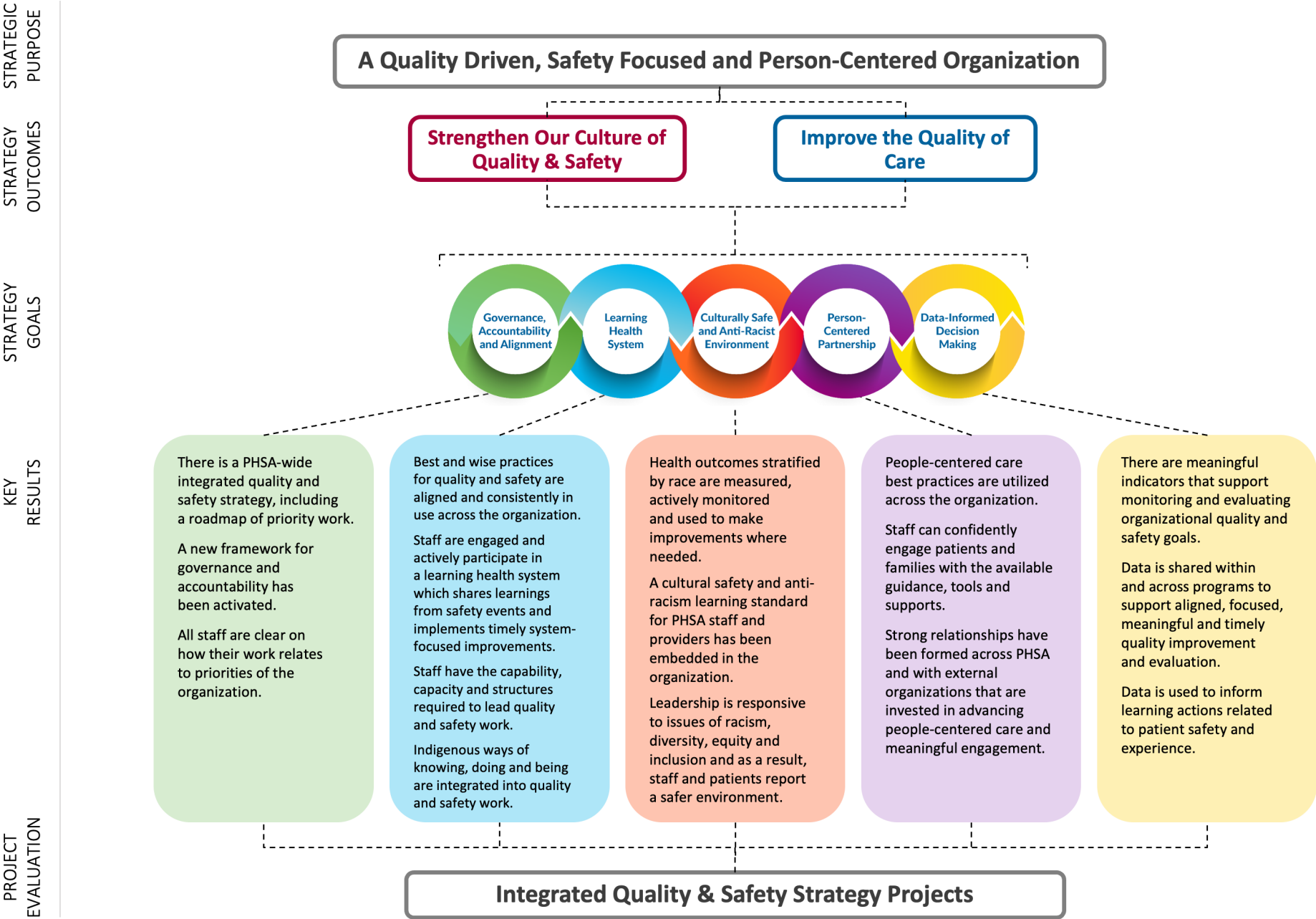
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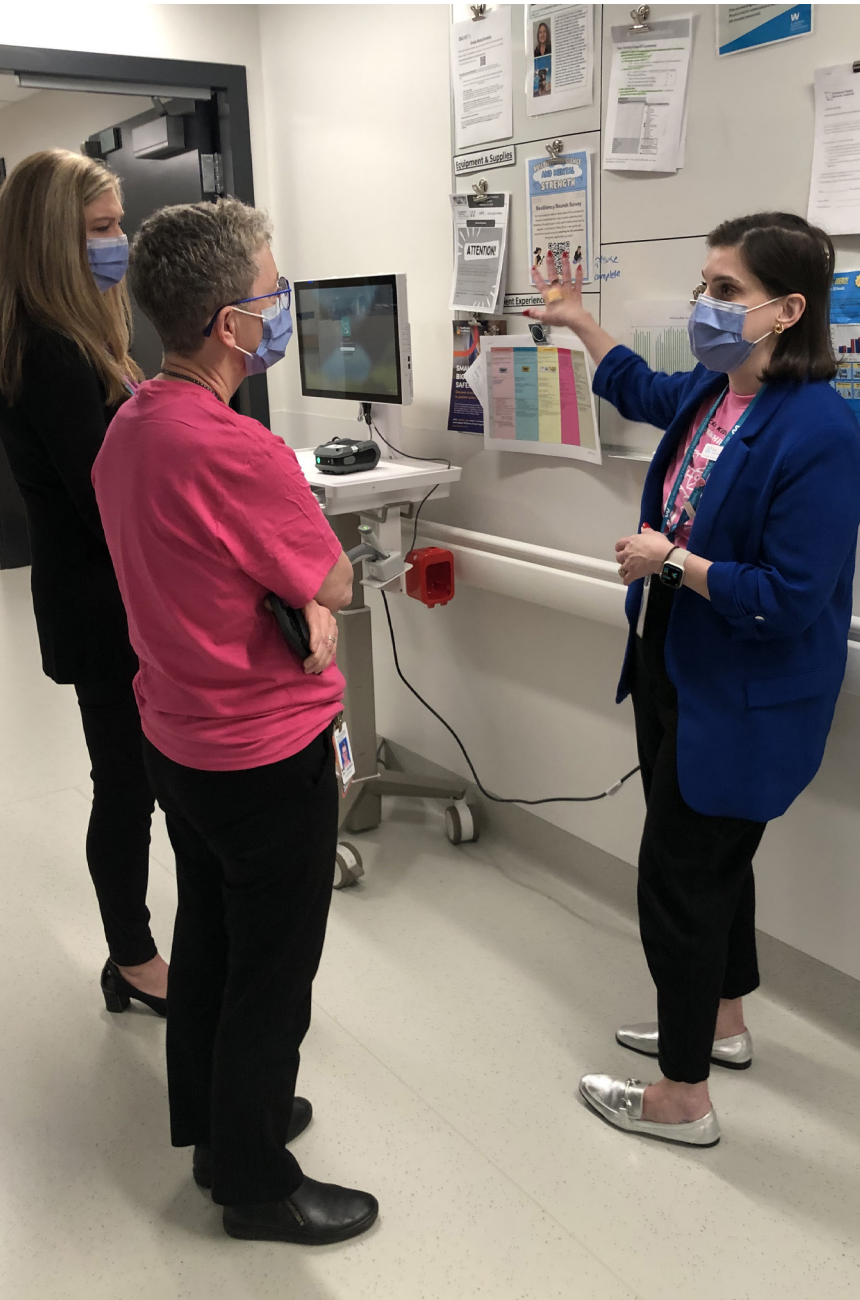
Looking Forward

The Integrated Quality & Safety Strategy was developed in 2022, establishing a strong framework for a more coordinated and strategic approach to quality and safety across PHSA.

Over the first 3 years, significant foundational work has been completed, creating a solid base for more complex projects and initiatives in the years ahead. As we move forward, our focus remains on continuous improvement, ensuring that the strategy evolves to meet emerging challenges and opportunities. Ongoing engagement with key partners will be central as we refine our approach, update the strategy, identify new projects, and drive meaningful, system-wide improvements. We remain committed to furthering our purpose ensuring that PHSA is a quality driven, safety focused and person-centered organization.

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5. **Health Quality BC.** *BC Health Quality Matrix.* 2023.



BC Women's Hospital What Matters to Your Rounds with Dr. Jana Davidson, CMO, Andrea Walker, Chief Quality, Patient Safety & Experience Officer, and Irene Ingel, Birthing & Surgical Services Obstetrics Program Manager.

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