Quality & Safety at PHSA

An Integrated Strategy

Provincial Health Services Authority

Quality, Practice & Clinical Informatics

Spring 2026

Table of Contents

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 and BCEHS boards.

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.

Several Members of PHSA's Central Quality, Patient Safety & Experience team May 2026

Land Acknowledgement

PHSA provides specialized health care services to communities across British Columbia, on the territories of 203 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), Sḵwx̱wú7mesh (Squamish Nation) and səl̓ílwətaɬ (Tsleil-waututh Nation) on whose unceded and ancestral territory our head office is located.

Coast Salish Teachings

The Coast Salish Teachings have been gifted to PHSA by Knowledge Keeper, Siem Te Ta-in, 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 Siem Te Ta-in and artist Atheana Picha

Quality & Safety at PHSA

PHSA 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 focus that brings together the core principles of quality and safety, the unique role of PHSA's clinical service delivery programs and the diversity of people across the health system. These common goals with clear actions 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 system[1]

Every **1 minute and 18 seconds** there is a patient safety event[2]

One of every eighteen hospitalized patients experience a preventable incidence of harm[3]

These events cost the health care system an additional **$2.75 billion** per year[2]

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 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. More than 200 participants, including medical staff and patient partners, took part in this engagement process by sharing their unique perspectives and ideas.

We've also drawn inspiration from leading organizations, including the Institute for Healthcare Improvement's Integrated Approach to Whole System Quality[5] and Canada's Patient Safety Framework for Health Services[6], 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 finalized 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, confirm current areas of focus, and identify future priorities.

The Strategy

There are 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.[7] 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, Siem Te Ta-in, 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 updated the visualization of the strategy to show the close connection between this work and each of the teachings.

With thanks to Siem Te Ta-in 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**

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.

Project Highlight

Surgical Project Quality Board at BC Cancer

Develop a Quality Boards & Safety Huddles Toolkit and Implement Across the Organization

Quality Boards and Safety Huddles are powerful tools for creating safer and more engaged care environments for both patients and staff. By making key quality, safety, and performance information visible, Quality Boards help teams develop a shared understanding of priorities, risks and progress, which improves consistency and prevents harm. Safety Huddles foster open communication, psychological safety, and rapid problem solving by giving each team member, clinical and non-clinical, a voice in identifying concerns and contributing solutions. This transparency and collective accountability strengthens trust, improves teamwork, and supports timely escalation of issues. Together these tools lead to better patient experiences, safer outcomes, and more efficient workflows.[8-11] They help build continuous quality improvement into everyday practice and increase quality improvement capacity across the organization. Additionally, implementing Quality Boards and Safety Huddles provides evidence to demonstrate compliance with multiple Required Organizational Practices (ROPs) and other key criteria for our Accreditation Canada survey. A toolkit that will support teams to implement Quality Boards and Safety Huddles across PHSA is currently in development. It will be adaptable across programs and will include a step-by-step guide, suggested components for the Quality Boards, and guidance for conducting Safety Huddles.

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 the Integrated Quality & Safety Strategy and roadmap of priority work.	✓
	Established Integrated Quality & Safety Strategy impact measures.	✓
2	Reviewed and mapped current state of the Quality & Safety Committee structures across PHSA programs.	✓
	Updated and aligned program Quality & Safety Committee terms of reference.	✓
	Determined reporting relationships between operations, quality & safety, and medical leadership across PHSA and within each program and documented these partnerships in integrated organizational charts.	✓
	Defined roles and responsibilities of operational quality & safety directors and their senior medical dyad partners.	✓
	Established the PHSA Integrated Quality & Safety Steering Committee.	✓
	Refresh Integrated Quality & Safety Steering Committee to align with new PHSA organizational structure.	●
	Clearly articulate the roles and responsibilities of Quality & Safety medical leaders and their operational partners.	●
	Develop a leadership coaching program for operational quality & safety and medical dyad partners.	●
	Pilot a centralized team facilitating critical comprehensive patient safety event reviews.	●
3	Reviewed and aligned roles and responsibilities for Quality & Safety team members.	✓
	Develop Quality Boards and Safety Huddles Toolkit and implement across the organization.	●
	Establish strategy deployment (catchball) for priority setting within programs.	●

LEGEND – PROJECT STATUS ✓ COMPLETE ● IN PROGRESS ● NEXT UP ● FUTURE PRIORITY

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.*

The Four Learner Groups from the PHSA QI Education Framework

Project Highlight

Create a PHSA Quality Improvement Education Framework

Quality improvement (QI) is a shared responsibility across PHSA, while education needs vary across the organization. To inform the development of PHSA's Quality Improvement Education Framework, an environmental scan of QI education offerings across Canada and internationally was conducted, including a review of approaches used by other BC health authorities. A collaborative, with representation from all program areas and subject matter experts, was created to define learner groups, identify knowledge and skills for each learner group establish learning goals, and align appropriate education. The resulting QI Education Framework provides a structured, organization-wide approach to building QI capability. Next steps include developing an updated online QI course to address a key gap identified through this project and then working with the collaborative, along with all quality directors to support dissemination across our clinical service delivery programs.

ACTIVITIES TO ACHIEVE GOAL 2

OKR	PROJECTS — **OKR** = Objectives and Key Results	STATUS
1	Created a Patient Safety Policy to streamline information from six existing policies.	✓
	Developed and implemented an efficient and aligned patient safety event review process with new tools and resources.	✓
	Developed an early notification process for potential critical events.	✓
	Developed a Serious Adverse Drug Reactions Procedure.	✓
	Developed a Medical Device Incident Procedure.	✓
	Developed the Speak Up for Patient Safety Procedure and launched with a robust communications and education plan.	✓
	Develop and implement a PHSA Hand Hygiene Framework.	●
	Refresh PHSA's accreditation approach to assess some standards system-wide before the sequenced on-site surveys.	●
	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 & families about quality and safety topics.	✓
	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.	✓
	Implement an Institute for Healthcare Improvement 'Break the Rules' pilot.	●
	Expand the Continuous Improvement Learning Community of Practice to other program areas.	●
3	Coordinated a disclosure education strategy for care providers and implemented key updates to the curriculum.	✓
	Developed orientation and onboarding process and materials for quality & safety leaders.	✓
	Defined Patient Safety Event Review chair roles and responsibilities.	✓
	Create a PHSA Quality Improvement Education Framework and develop an associated PHSA e-course.	●
	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	●

LEGEND – PROJECT STATUS ✓ COMPLETE ● IN PROGRESS ● NEXT UP ● FUTURE PRIORITY

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 Highlight

Developed and Implemented Organization-Wide Reporting and Responding to Harm from Indigenous-Specific Racism and Discrimination (ISRD) Education Strategy

Following the launch of the Reporting and Responding to Harm from ISRD Protocol, a comprehensive education strategy was implemented to build awareness and knowledge of this protocol. This strategy included an organization-wide online course, a three-part microlearning series for all staff, and workshops for key partners. These workshops included half-day workshops for Quality, Risk, Patient Care Quality Office, and Indigenous Health teams who are actively involved in ISRD reviews. Post-workshop evaluation indicated improved staff understanding of the new ISRD protocol, increased confidence in recognizing different forms of ISRD, and greater clarity on their role in addressing and eradicating Indigenous-specific racism and discrimination.

Quality & Safety team members, Terrace Desnomie and Ole Olsen, at a Patient Safety Event Review workshop

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 protocol for reviewing Indigenous-specific racism and discrimination that caused patient or family harm.	✓
	Completed a self-assessment on the first three sections of the Cultural Safety and Humility Health Standards Organization Standard (CSH HSO Standard).	✓
	Prepare a communications plan for all staff about the CSH HSO Standard.	●
	Develop a standard for the tracking and trending of no and low harm patient safety events that involve Indigenous patients.	●
	Guide an organization-wide self-assessment for the CSH HSO Standard	●
3	Determined racism reviews not appropriate for Section 51 protection.	✓
	Prepared an Indigenous-led Resolution Guide.	✓
	Developed and implemented organization-wide reporting and responding to harm from Indigenous-specific racism and discrimination education strategy.	✓
	Develop and implement a prompt to report racism and discrimination as a cause of harm in the Patient Safety and Learning System.	●
	Develop and implement a process to report and review psychological harm to patients and families resulting from patient safety events.	●

LEGEND – PROJECT STATUS ✓ COMPLETE ● IN PROGRESS ● NEXT UP ● FUTURE PRIORITY

Goal 4 Person-Centered Partnership

Create meaningful partnerships with patients, families and caregivers to support collaboration, build trust throughout their care journey and include their perspectives 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.

Project Highlight

Framework for Patient and Family Partner Participation in Patient Safety Event Reviews pilot

Establish Patient Partner Participation in Patient Safety Event Reviews (PSERs)

Patient and Family Partners (PFPs) offer perspectives and insights that may not be captured through system sources such as staff reports or medical records. Their involvement helps identify contributory factors and system blind spots, strengthens the completeness and relevance of the learning, and anchors recommendations in real-world patient and family experiences. A framework providing guidance for staff on effective and safe collaboration with PFPs in Patient Safety Event Reviews has been developed and is being piloted with the BC Children's Hospital Emergency Department. In 2026, expanded communication and education initiatives will support the spread of this best practice across the organization.

> By engaging patients and their families at multiple levels of the organizational performance, we can not only improve their own health care experiences but also gain valuable insights for actions necessary to improve the health of populations and to extract greater value from our limited health care resources."
> **– Institute for Healthcare Improvement**[12]

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 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).	○
	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 and implemented a playbook and guidance for recognition, honorariums and expenses for patient and family partners at PHSA.	✓
	Developed and facilitated patient and family engagement learning series.	✓
	Developed and implemented a strategy for patient and family partner engagement in policy work.	✓
	Establish patient partner participation in patient safety event reviews.	●
	Develop a toolkit and run a pilot to include patient partners on hiring panels.	●
	Develop a PHSA-wide patient partner orientation and onboarding program.	●
	Implement a hub and spoke model for communicating engagement opportunities.	●
	Include patient and family partners in staff orientations.	○
	Update leadership job descriptions to include patient and family centered care competencies.	○
3	Hosted a PHSA Patient Experience and Partnerships Symposium.	✓
	Established a Patient and Community Engagement Community of Practice.	✓
	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.	○

LEGEND – PROJECT STATUS ✓ COMPLETE ● IN PROGRESS ● NEXT UP ○ FUTURE PRIORITY

Snapshot of Patient and Family Partner Engagement Across PHSA

Patient and family engagement is embedded across PHSA programs with patient and family partners (PFPs) contributing to a wide range of committees, projects, and advisory structures that support system improvement and decision-making. These partnerships support better experiences, improve quality, and create more responsive health services.

This snapshot provides a high-level overview of engagement activity across the 2025/26 fiscal year based on available program data. Programs vary in how engagement is structured, delivered and tracked which impacts the data shown here. The purpose of this snapshot is to highlight the breadth of work underway, not comparison across programs. More detailed information, including stories, examples, and program-specific approaches can be found in individual program reports on PHSA's internal website, POD.

Over this past year, more than 350 engagement projects have been completed, involving almost 1400 patient and family partners!

	 Patient & Family Partners (PFPs)	 Engagement Projects	 Committees with PFP representation	 Patient & Family Advisory Councils
PHSA Central	32	7	1	0
BC Cancer	154	128	37	4
BC Centre for Disease Control	86	32	8	9
Chee Mamuk	55	39	6	3
BC Emergency Health Services	12	2	1	0
BC Mental Health & Substance Use Services	53	47	14	1
BC Renal	30	4	15	1
BC Children's Hospital and BC Women's Hospital & Health Centre	693	90	2	25
Provincial Language Services	278	3	0	3

Note: Some patient and family partners may be involved in more than one PHSA program and therefore be counted more than once.

Chee Mamuk is an Indigenous program within the BC Centre for Disease Control that uses co-design methods to inform the delivery of health and wellness initiatives for Indigenous communities.

Goal 5 Data-Informed Decision Making

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

	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 Highlight

Generate a Patient Safety and Learning System (PSLS) Dashboard and Report for Program Quality & Safety Committee Review and Board Awareness

Quality & Safety teams and Quality & Safety Committees need access to PSLS data to understand how the organization reports and responds to patient safety events, key indicators of a strong culture of quality and safety. Last fiscal year, a dashboard was developed to provide visibility into key metrics including reporting volume, severity, anonymous reporting, and responsiveness to events. In July 2025, PHSA implemented a new PSLS platform, DCIQ, which required revision to the dashboard design and data structure. The updated dashboard is scheduled to launch in mid-2026. An annual report will also be developed to support Program Quality & Safety Committee and Board-level oversight of PSLS reporting trends.

BC Mental Health & Substance Use Quality & Safety Team

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.	✓
	Implement Health Standards Organization's Global Workforce Survey.	●
	Develop and implement a patient safety culture pulse check survey.	●
	Expand the use of cultural safety and humility indicators in the Quality & Safety Indicator Reports across all clinical service delivery program areas.	●
	Implement the Office of Patient Centred Measurement (OPCM) provincial patient engagement measurement strategy.	●
	Design local patient experience measurement approaches including processes for reporting, learning and action based on the data.	●
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 an annual report on the Indigenous-specific racism and discrimination reviews and recommendation implementation.	✓
	Developed a PHSA-wide database to track and report on recommendation implementation status from critical comprehensive patient safety event reviews.	✓
	Generate a Patient Safety and Learning System dashboard and report for Program Quality & Safety Committee review and board awareness.	●
3	Determined 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.	●
	Enable PHSA governance and executive teams to use patient experience data in planning, priority setting, and decision making.	●

LEGEND – PROJECT STATUS ✓ COMPLETE ● IN PROGRESS ● NEXT UP ● FUTURE PRIORITY

Measuring Impact

The Integrated Quality & Safety Strategy influences PHSA at multiple levels. Therefore, the evaluation requires a multi-modal approach that considers impact at the project, goal and strategy level.

Strategy-Level:

The overall impact of the strategy is evaluated against two long-term outcomes, ***strengthening our culture of quality and safety*** and ***improving the quality of care***. These are influenced by many factors across the organization and reflect the broader purpose of the strategy, to support PHSA in being a quality driven, safety focused and person-centered organization.

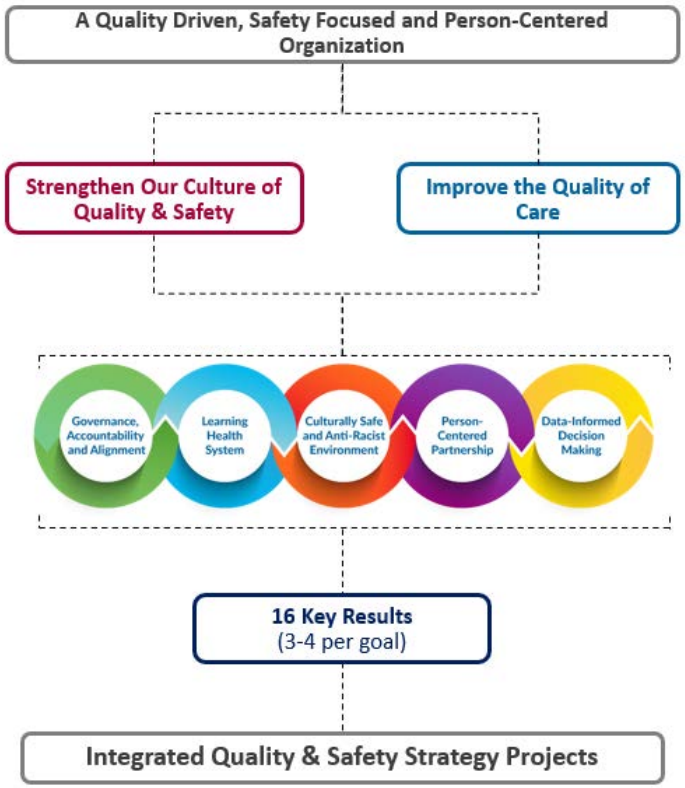
Culture of quality and safety will be measured using feedback from across PHSA. Planning is underway for an all-staff HSO Global Workforce Survey, along with a smaller-scale and more frequent Patient Safety Culture Pulse Check Survey. Together, these tools will assess:

- ✓ Overall perception of quality and patient safety at PHSA
- ✓ The extent to which staff feel safe reporting patient safety events
- ✓ The extent to which staff feel empowered to improve patient safety and quality
- ✓ The extent to which PHSA actively partners with patients and families to improve the health care system
- ✓ The extent to which patients feel involved in decisions about their care

Quality of care will be evaluated using data from the Quality & Safety Indicator Reports, Patient Reported Experience and Outcome Measures, and the Patient Safety and Learning System.

Project & Goal Level:

Each project is evaluated to determine whether its intended outcomes have been achieved and to identify opportunities for improvement. Each goal is evaluated by determining progress towards its key results. This evaluation is influenced by strategy projects and other related initiatives across the organization.



Key Results

Each key result contributes to achieving the intended impact of the Integrated Quality & Safety Strategy. In total, the strategy includes 16 key results across its 5 goals. Over the next three pages, each key result is presented alongside select metrics and highlights from the past fiscal year to show progress made and areas of focus.

Reviewing progress to date provides an opportunity to better understand the impact of the strategy thus far, recognize areas of achievement, and identify opportunities for further action. Taken together, these reflections help inform where continued effort, adjustment, or additional support may be needed in the years ahead.

Quality & Safety Huddle at BC Cancer - Vancouver

Key Results This Fiscal Year by Goal

1. There is a PHSA-wide Integrated Quality & Safety Strategy, including a roadmap of priority work.

46 projects completed within the Integrated Quality & Safety Strategy

Strategy Measures Endorsed and will be evaluated using upcoming all staff surveys

Engagement Planned to confirm current and identify future priorities and direction of this strategy

2. A new framework for governance and accountability for quality and safety has been activated.

Dyad Model for Q&S and Medical Leadership was used to inform job descriptions for new leaders

All Programs have up-to-date org charts showing Quality Director reporting relationships & partnerships

Committee Refresh the Integrated Q&S Committee membership and terms of reference are being refreshed

3. All staff are clear on how their work relates to priorities of the organization.

Quality & Safety Boards Toolkit is under development to help direct care staff connect their work to PHSA priorities and QI

All Staff Survey will explore how staff view the connection between their work and the priorities of the organization

1. **Best and wise practices for quality and safety are aligned and consistently in use across the organization.**

All Q&S Policy Documents have been reviewed or updated in the last 3 years

All Programs are using the updated Patient Safety Event Review Protocol and associated tools

Speak up for Patient Safety Procedure went live alongside a robust education & communications plan

2. **Staff are engaged and actively participate in a learning health system which shares learnings from safety events and implements timely system-focused improvements.**

75% of Programs have prepared at least one learning summary to share anonymized learnings from a patient safety event review

Hand Hygiene Framework launched alongside a suite of QI tools to help leaders take actionable steps to improving this vital safety measure

3. **Staff have the capability, capacity and structures required to lead quality and safety work.**

15 Chair Responsibilities were defined to help provide clarity for patient safety event reviews

4 Learner Groups in the QI Framework were developed and endorsed leading to a new online course next fiscal year

Orientation & Onboarding materials launched for Q&S Leaders to support them and managers in their first year

4. **Indigenous ways of knowing, doing and being are integrated in quality and safety work.**
Integrated into all Integrated Q&S Strategy Projects. Impact and evaluation captured in Goal 3.

1. **Health outcomes stratified by race are measured, actively monitored and used to make improvements where needed.**

Enhanced Review Module in PSLS has been developed to store reports and learnings from ISRD Reviews

94% of participants self-reported confidence in applying the ISRD Protocol after attending a workshop

43% of PSLS Events had **unknown** Indigenous Self-ID, highlighting an opportunity to improve this data

2. **A cultural safety and anti-racism learning standard for PHSA staff and providers has been embedded in the organization.**

16 Education Sessions on ISRD were attended by 677 PHSA Staff

19 Criterion of the Cultural Safety and Humility (CSH) Standard have been self-assessed by a PHSA Working Circle

A Communication Plan for the CSH Standard is under development to help promote awareness for all staff

3. **Leadership is responsive to issues of racism, diversity, equity and inclusion and as a result, staff and patients report a safer environment.**

22 Reviews of ISRD were finalized at the Thee Eat and ISRD Response Committee

80 Recommendations were developed to address ISRD

Indigenous Led Resolution Guide was developed to support staff engaging meaningfully in the resolution process and address harmful experiences

Person-Centered Partnership

1. **People-centered care best practices are utilized and launched across the organization.**

1569 Views this fiscal year on the enhanced Patient and Family Engagement Central Hub on POD

4 PFPs onboarded to participate in PSER Pilot at BC Children's Hospital using a new framework launched in 2025

3 Leadership Hiring Panels included at least one of the 6 Patient and Family Partner (PFP) onboarded to support this work

2. **Staff can confidently engage patients and families with the available guidance, tools and supports.**

233 Attendees at the Patient and Family Engagement Learning Series

72% More Confident in patient engagement after attending learning series

95% Intend to Apply what they learned at the learning series to their work

3. **Strong relationships have been formed across PHSA and with external organizations that are invested in advancing people-centered care and meaningful engagement.**

55 Members of the Patient and Community Engagement Community of Practice met 8 times

7 Meetings of the Patient Experience and Partnership Steering Committee which has 25 members

130 Committees with PFP representation across PHSA including Quality Committees and Patient and Family Advisory Councils

Data-Informed Decision Making

1. **There are meaningful indicators that support monitoring and evaluating organizational quality and safety goals.**

All Staff Survey planning is underway to launch a new all staff survey at PHSA next fiscal year

4 Indicators in the PSLS Dashboard allowing Q&S teams and committees direct access to insights from this rich data

2 Cultural Safety Indicators included in the quarterly Q&S Indicator Reports with efforts underway to refresh these reports

2. **Data is shared within and across programs to support aligned, focused, meaningful and timely quality improvement and evaluation.**

ISRD Report prepared for the Thee Eat Committee and PHSA Executive team to provide insight on reviews and recommendation status

Patient Safety Event Review Trackers have been updated to allow for automated reporting to the Program Q&S Committees and Board on recommendation status

3. **Data is used to inform learning actions related to patient safety and experience.**

1393 Patient and Family Partners engaged across PHSA to inform initiatives and quality improvement

352 Engagement Projects & Co-Design shaping the future of care and improving patient safety and experience

Patient Care Quality Office Data is being shared with Q&S Committees to inform quality improvement initiatives across PHSA

Looking Forward

The Integrated Quality & Safety Strategy, developed in 2022, established a strong framework for a more coordinated and strategic approach to quality and safety across PHSA. Over the first four years, significant foundational work has been completed, creating a solid base for more complex projects and initiatives in the years ahead.

This fiscal year, the strategy continued to have a positive impact across PHSA. At the sametime, progress on select initiatives slowed as the organization underwent a comprehensive review of its structure, processes and purpose. This period of transition, including the introduction of an interim board and CEO, led to shifts in organizational priorities and the pacing of some projects.

As PHSA moves forward as a more clinically focused organization, the strategy will be reviewed and refreshed to ensure continued alignment with emerging priorities and system needs. In the coming fiscal year, meaningful and robust engagement activities will be conducted, including an all-staff patient safety survey, to inform this update and to identify opportunities to further strengthen PHSA as a quality-driven, safety-focused and person-centered organization.

Dr. Sean Virani, interim CEO at PHSA, attending a Quality & Safety Walkabout at the BCEHS Vancouver Dispatch Centre with Ford Smith and Kathy Pascuzzo.

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