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Health Technology Assessment Unit (TAU) of the MUHC



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## Insights from Patient Safety Week 2025: Strengthening Our Culture of Safety Across MUHC Sites

Health Technology Assessment:  
Brief Report  
Report no. 106

# Report prepared for the Technology Assessment Unit (TAU) of the McGill University Health Centre (MUHC)

by

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## **Mission Statement**

The MUHC Health Technology Assessment Unit (TAU) advises hospital administrators and clinical teams in difficult resource allocation decisions. Using an approach based on independent, critical evaluations of the available scientific evidence and a transparent, fair decision-making process, novel and existing medical equipment, drugs and procedures used by healthcare professionals are prioritized on a continuous basis ensuring the best care for life with the best use of resources.

## **Declaration of Conflicts of Interest**

Members of TAU's research staff and policy committee declare no conflicts of interest.

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## SUMMARY

### BACKGROUND

Canadian Patient Safety Week (PSW), led by Healthcare Excellence Canada, is a national campaign aimed at advancing safety culture across healthcare systems. In October 2025, the MUHC mobilized PSW activities across our five hospital sites under the theme “*All Voices for Safer Care*”, emphasizing collective responsibility, open dialogue, and systems that enable every voice to be heard.

Moving beyond traditional awareness activities, this year we leveraged PSW as a strategic opportunity to capture frontline and patient insights and translate them into actionable system-level priorities.

This work reflects the principles of a **Learning Health System**, where data generated through care experiences are continuously analyzed and reintegrated into improvement efforts. This initiative also represents a cross-collaborative effort between the Quality & Risk (Q&R) team and the Health Technology Assessment Unit (TAU) of the Directorate of Quality, Innovation and Performance, underscoring that shared expertise can enable structured analysis and continuous improvement.

### OBJECTIVES

This report aims to:

1. Evaluate feedback from frontline staff and patients on observed safety behaviours, strengths, and improvement opportunities.
2. Identify safety themes and map them to Accreditation Canada Required Organizational Practices (ROPs).
3. Triangulate qualitative insights with objective performance metrics to identify convergent trends and areas for system-level improvement.
4. Generate actionable, system-level recommendations to strengthen MUHC’s safety culture.

### METHODS

- **Data collection:** Feedback was collected from frontline staff and patients during PSW activities in October 2025 using interactive ‘safety walls’ i.e. engagement boards that solicited responses using the prompt: “I see safer care in action when...”
- **Analysis:** Collected feedback was analysed in multiple steps:
  1. First, responses were grouped according to perceived strengths (green), areas for improvement (red), or areas to maintain/reinforce (yellow).

2. Next, a qualitative thematic analysis identified key safety themes and mapped them to Accreditation Canada ROPs. This enabled the creation of a cross-site comparative snapshot using a traffic light framework.
3. As a validity check, findings were triangulated against objective measures obtained from hospital scorecards.
4. Finally, improvement opportunities were identified based on the most-commonly recurring themes across site, and grouped according to jurisdictions for action: Executive-level, local-level, and broader community.

## RESULTS

- A total of 184 responses were collected across five sites, which showcased broad representation from clinical, operational and patient perspectives.
- **Six core safety themes** emerged from the qualitative thematic analysis:
  1. Patient-centred communication & engagement;
  2. Safety practices & culture;
  3. Teamwork & collaboration;
  4. Workforce & systems readiness;
  5. Safe environment & equipment;
  6. Care coordination & accessibility.
- **Cross-site common strengths:**
  - **Patient communication & engagement** and **Teamwork & collaboration** were consistently strong across all sites and emerged as a core organizational strength.
- **Cross-site common gaps:**
  - **Workforce & systems readiness** (e.g. staffing pressures, workflow inefficiencies), **Physical environment & equipment** (e.g. clutter, accessibility), and **Care coordination & accessibility** (e.g. appointment scheduling, inter-site communication) were cited as areas for improvement.
- **Cross-site areas to maintain/reinforce:**
  - **Safety practices & culture** (e.g., hand hygiene, double identification, medication safety) are well established but require ongoing reinforcement.
- **Alignment with objective data:** Preliminary analysis suggests good convergence between perceptions and measured performance, particularly for strengths in patient communication and engagement, and concerns regarding safe environment and care coordination.
- **Four high-impact, priority areas were identified:**
  1. Accessibility and infrastructure improvements

2. Environmental cleanliness and organization
3. Equipment availability (e.g., wheelchairs, monitoring tools)
4. Reinforcement of safety practices and just culture

## CONCLUSIONS

- This cross-site Patient Safety Week initiative successfully demonstrates how structured engagement with patients, families, and frontline staff can serve as a strategic organizational learning mechanism.
- By systematically capturing and analyzing 184 narrative responses across five MUHC sites, this initiative intended to generate value by translating insights into actionable safety data aligned with Accreditation Canada Required Organizational Practices (ROPs).
- Our findings reveal that the MUHC has a strong cultural foundation in communication and teamwork, but also system-level challenges related to infrastructure, and coordination.
- The consistency of themes across sites, and their alignment with objective data, supports the validity of frontline and patient perspectives as a critical complement to traditional performance metrics.
- By transforming narrative feedback into structured insights, this initiative operationalizes the principles of a **Learning Health System**, whereby data generated in routine care are transformed into knowledge and reintegrated into decision-making processes. It highlights the potential of Patient Safety Week to function not only as an engagement activity, but as a repeatable, low-cost learning cycle that strengthens the MUHC's capacity for responsiveness, shared accountability, and continuous improvement.

## RECOMMENDATIONS

### 1. Institutionalize Patient Safety Week as a learning cycle

- Formalize PSW as an annual organizational learning intervention, with standardized processes for data collection, analysis, and reporting.
- Ensure findings are systematically fed into governance structures, quality committees, and strategic planning processes to complete the feedback loop.

### 2. Reinforce safety practices and Just Culture

- Sustain and strengthen core safety behaviours (e.g., hand hygiene, double identification, medication safety) through ongoing education and reinforcement.
- Promote a just culture by encouraging speaking up, near-miss reporting, and shared accountability across all levels of the organization.

### 3. Engage local-level levers to implement improvements

- Empower local managers to implement unit-level improvements (e.g., decluttering, signage, workflow optimization, mobility support).
- Engage patients, families, and volunteers through targeted safety awareness campaigns (e.g., falls prevention, identification checks, Vanessa's Law).

### 4. Advance data valorization and measurement

- Continue triangulating qualitative feedback with quantitative indicators to validate findings and monitor impact.
- Develop key performance indicators (KPIs) and key behavioural indicators (KBIs) linked to identified priorities (e.g., accessibility, coordination, responsiveness).

### 5. Close the feedback loop

- Communicate results and resulting actions back to staff and patients to reinforce trust, engagement, and transparency.
- Demonstrate how feedback leads to tangible improvements, thereby strengthening participation in future initiatives.

## SOMMAIRE

### CONTEXTE

La Semaine nationale de la sécurité des patients (SNSP), menée par Excellence en santé Canada, est une campagne nationale visant à promouvoir une culture de sécurité dans l'ensemble des systèmes de santé. En octobre 2025, le CUSM a déployé les activités de la SNSP dans ses cinq établissements hospitaliers sous le thème « *Des soins plus sûrs, portés par toutes les voix* », mettant l'accent sur la responsabilité collective, le dialogue ouvert et les systèmes qui permettent à chacun de se faire entendre.

Dépassant les activités de sensibilisation traditionnelles, nous avons profité cette année de la SNSP comme d'une occasion stratégique pour recueillir les points de vue des intervenants de première ligne et des patients et les traduire en priorités systémiques concrètes.

Ce travail reflète les principes d'un système de santé apprenant, où les données issues des expériences de soins sont analysées en continu et réintégrées aux efforts d'amélioration. Cette initiative représente également une collaboration interdisciplinaire entre l'équipe Qualité et Risques (Q&R) et l'Unité d'évaluation des technologies de la santé (UETMIS) de la Direction de la qualité, de l'innovation et de la performance, soulignant que le partage d'expertise peut favoriser une analyse structurée et une amélioration continue.

### OBJECTIFS

Ce rapport vise à :

1. Évaluer les commentaires du personnel de première ligne et des patients sur les comportements observés en matière de sécurité, les points forts et les pistes d'amélioration.
2. Identifier les thèmes liés à la sécurité et les associer aux pratiques organisationnelles requises (POR) d'Agrément Canada.
3. Trianguler les données qualitatives avec des indicateurs de performance objectifs afin de dégager les tendances convergentes et les domaines à améliorer à l'échelle du système.
4. Formuler des recommandations concrètes à l'échelle du système pour renforcer la culture de sécurité du CUSM.

## MÉTHODES

- **Collecte de données** : Des commentaires ont été recueillis auprès du personnel de première ligne et des patients lors des activités de soutien aux patients en octobre 2025, au moyen de « murs de sécurité » interactifs (panneaux d'affichage) invitant à répondre à l'aide de la question : « Une action concrète pour des soins plus sûrs, c'est... »
- **Analyse** : Les commentaires recueillis ont été analysés en plusieurs étapes :
  1. Les réponses ont d'abord été regroupées selon les points forts perçus (vert), les points à améliorer (rouge) et les points à maintenir/renforcer (jaune).
  2. Une analyse thématique qualitative a ensuite permis de cerner les principaux thèmes liés à la sécurité et de les associer aux pratiques organisationnelles requises (POR) d'Agrément Canada. Cela a permis de créer un aperçu comparatif intersites à l'aide d'un système de feux tricolores.
  3. Afin de vérifier la validité des résultats, ceux-ci ont été triangulés à l'aide de mesures objectives provenant des tableaux de bord des hôpitaux.
  4. Enfin, des pistes d'amélioration ont été identifiées en fonction des thèmes les plus récurrents sur l'ensemble des sites et regroupées selon les niveaux de responsabilité : direction, administration locale et communauté élargie.

## RÉSULTATS

- Au total, 184 réponses ont été recueillies sur cinq sites, reflétant une large représentation des perspectives cliniques, opérationnelles et des patients.
- **Six thèmes** clés liés à la sécurité ont émergé de l'analyse thématique qualitative :
  - Communication et implication centrées sur le patient ;
  - Pratiques et culture de sécurité ;
  - Travail d'équipe et collaboration ;
  - Préparation du personnel et des systèmes ;
  - Environnement et équipement sécuritaires ;
  - Coordination et accessibilité des soins.
- **Points forts communs à tous les sites** :
  - **La communication et l'implication des patients**, ainsi que le **travail d'équipe et la collaboration**, ont été des points forts constants sur tous les sites et constituent un atout organisationnel majeur.
- **Points faibles communs à tous les sites** :
  - **La préparation du personnel et des systèmes** (par exemple, les tensions sur les effectifs, les inefficacités des flux de travail), **l'environnement physique et l'équipement** (par exemple, l'encombrement, l'accessibilité) et la

**coordination et l'accessibilité des soins** (par exemple, la prise de rendez-vous, la communication inter-sites) ont été cités comme des axes d'amélioration.

- **Domaines transversaux à maintenir/renforcer :**
  - **Les pratiques et la culture de sécurité** (p. ex., hygiène des mains, double identification, sécurité des médicaments) sont bien établies, mais nécessitent un renforcement continu.
  - **Concordance avec les données objectives :** L'analyse préliminaire suggère une bonne convergence entre les perceptions et les performances mesurées, notamment en ce qui concerne les points forts de la communication et de l'implication des patients, ainsi que les préoccupations relatives à la sécurité de l'environnement et à la coordination des soins.
  - **Quatre domaines prioritaires** à fort impact ont été identifiés :
    1. Amélioration de l'accessibilité et des infrastructures
    2. Propreté et organisation de l'environnement
    3. Disponibilité du matériel (par exemple, fauteuils roulants, outils de surveillance)
    4. Renforcement des pratiques de sécurité et de la culture de la sécurité

## CONCLUSIONS

- Cette initiative intersites de la Semaine de la sécurité des patients démontre avec succès comment une mobilisation structurée des patients, des familles et du personnel de première ligne peut servir de mécanisme stratégique d'apprentissage organisationnel.
- En recueillant et en analysant systématiquement 184 réponses narratives provenant de cinq sites du CUSM, cette initiative visait à créer de la valeur en transformant les observations en données de sécurité exploitables, conformes aux pratiques organisationnelles requises (POR) d'Agrément Canada.
- Nos résultats révèlent que le CUSM possède une solide culture de communication et de travail d'équipe, mais aussi des défis systémiques liés à l'infrastructure et à la coordination.
- La cohérence des thèmes d'un site à l'autre et leur concordance avec les données objectives appuient la validité des perspectives du personnel de première ligne et des patients, qui constituent un complément essentiel aux indicateurs de performance traditionnels.
- En transformant les commentaires narratifs en observations structurées, cette initiative met en œuvre les principes d'un **système de santé apprenant**, où les

données générées dans le cadre des soins courants sont transformées en connaissances et réintégrées aux processus décisionnels. Elle met en lumière le potentiel de la Semaine de la sécurité des patients à fonctionner non seulement comme une activité de mobilisation, mais aussi comme un cycle d'apprentissage reproductible et peu coûteux qui renforce la capacité du CUSM en matière de réactivité, de responsabilité partagée et d'amélioration continue.

## RECOMMANDATIONS

### 1. Institutionnaliser la Semaine de la sécurité des patients comme un cycle d'apprentissage

- Formaliser la Semaine de la sécurité des patients comme une intervention annuelle d'apprentissage organisationnel, avec des processus standardisés pour la collecte, l'analyse et la communication des données.
- S'assurer que les résultats sont systématiquement intégrés aux structures de gouvernance, aux comités de qualité et aux processus de planification stratégique afin de boucler la boucle de rétroaction.

### 2. Renforcer les pratiques de sécurité et la culture de la justice

- Maintenir et renforcer les comportements de sécurité fondamentaux (p. ex., hygiène des mains, double identification, sécurité des médicaments) par la formation continue et le renforcement des acquis.
- Promouvoir une culture de la justice en encourageant la prise de parole, le signalement des incidents évités de justesse et la responsabilité partagée à tous les niveaux de l'organisation.

### 3. Mobiliser les leviers locaux pour mettre en œuvre des améliorations

- Donner aux gestionnaires locaux les moyens de mettre en œuvre des améliorations au niveau de l'unité (p. ex., désencombrement, signalétique, optimisation des flux de travail, soutien à la mobilité).
- Mobiliser les patients, les familles et les bénévoles par le biais de campagnes de sensibilisation ciblées à la sécurité (p. ex., prévention des chutes, vérifications d'identité, loi Vanessa).

**RECOMMANDATIONS (cont.)****4. Valorisation et mesure des données**

- Continuer à croiser les données qualitatives avec des indicateurs quantitatifs afin de valider les résultats et d'en suivre l'impact.
- Élaborer des indicateurs clés de performance et des indicateurs clés de comportement liés aux priorités identifiées (p. ex., accessibilité, coordination, réactivité).

**5. Boucler la boucle de rétroaction**

- Communiquer les résultats et les actions qui en découlent au personnel et aux patients afin de renforcer la confiance, l'engagement et la transparence.
- Démontrer comment la rétroaction conduit à des améliorations concrètes, renforçant ainsi la participation aux initiatives futures.

**LIST OF ABBREVIATIONS**

AC	Accreditation Canada
HTA	Health technology assessment
MCH	Montreal Children’s Hospital
MGH	Montreal General Hospital
MSSS	Ministère de la Santé et des Services sociaux/Ministry of Health and Social Services
MUHC	McGill University Health Centre
PAB	Préposé aux bénéficiaires (orderlies)
PSW	Patient Safety Week
Q&R	Quality and Risk Team of the Directorate of Quality, Innovation and Performance of the MUHC
ROP	Required Organizational Practices
RVH	Royal Victoria Hospital
TAU	MUHC Technology Assessment Unit

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# INSIGHTS FROM PATIENT SAFETY WEEK 2025: STRENGTHENING OUR CULTURE OF SAFETY ACROSS MUHC SITES

## 1. CONTEXT

Canadian Patient Safety Week, organized by [Healthcare Excellence Canada \(HEC\)](#), is a national annual campaign designed to improve safety culture. From October 27 to 31, 2025, the MUHC marked **Patient Safety Week** across our five hospital sites: the Royal Victoria Hospital (RVH), Montreal General Hospital (MGH), Lachine Hospital, the Montreal Neurological Hospital (Neuro), and the Montreal Children's Hospital (MCH).

The theme, "**All Voices for Safer Care**," invited patients, families, and staff to share reflections on what supports safe, compassionate care and what could be improved.

### 1.1 Learning Health Systems

Patient Safety Week (PSW) initiatives are commonly implemented as awareness campaigns but are rarely embedded within formal governance, prioritization, and improvement frameworks. We therefore aimed to leverage this year's PSW opportunity to transform qualitative safety narratives into structured, actionable priorities aligned with accreditation standards and organizational governance structures.

This initiative enforces the principles of Learning Health Systems (LHS) that continuously and systematically integrate data generated in care delivery into improvement cycles. This year's PSW theme emphasized listening more deeply, asking important questions, and taking meaningful action, which perfectly encompass the data to action learning loops of an LHS.

### 1.2 A cross-collaborative effort of the Directorate of Quality

The annual Patient Safety Week initiative at our hospital is led by the Quality and Risk team (Q&R) of the hospital's Directorate of Innovation, Performance and Quality (DIPQ), wherein Q&R staff prepare activities and material to actively solicit feedback across our five hospital sites with the overarching objective of improving safety culture.

This year, the Q&R team joined forces with the Health Technology Assessment Unit (TAU) to qualitatively analyze the collected feedback and translate it into actionable recommendations to improve safety culture.

## 2. OBJECTIVE OF THE REPORT

The objectives of this report are to:

1. Evaluate feedback gathered from frontline staff and patients on observed safety behaviours, strengths, and improvement opportunities.
2. Identify safety themes and map them to Accreditation Canada Required Organizational Practices (ROPs).
3. Triangulate qualitative insights with objective safety and satisfaction metrics to identify convergent trends and areas for system-level improvement.
4. Generate actionable, system-level recommendations to strengthen MUHC's safety culture.

## 3. METHODS

### 3.1 Data collection

- Feedback was collected during Patient Safety Week activities (October 2025) through interactive boards (*Safety Walls*, [Figure 1A](#)), written reflections, and direct staff/patient input. Safety Walls consisted of two large tri-fold posters as fixed “walls” and two smaller posters as mobile boards that were carried into care units to directly interact with point-of-care staff. Feedback was solicited using the following prompt cards provided by Health Excellence Canada: “I see safer care in action when...” ([Figure 1B](#)).
- This represented a change from previous PSW activities, where kiosks had low engagement. The shift to a **structured, interactive approach** was designed to encourage greater participation.
- The active support of clinical champions further engaged units and boosted response rates.



Figure 1. (A) Safety Wall interactive boards used during Patient Safety Week. (B) Feedback prompt

### 3.2 Analytic approach

- **Grouping by Perceived Performance:** We first analyzed all the written feedback and grouped them according to perceived strengths, gaps, or areas to maintain/re-enforce.
- **Mapping to safety themes:** We then performed a qualitative thematic analysis using inductive coding to identify safety themes aligned with Accreditation Canada's Required Organizational Practices (ROPs). Broadly, the thematic analysis involved reviewing the raw data (184 comments), assigning initial codes based on the guiding question "What are contributing factors to safer care?" and then sorting the initial codes into overarching, distinct safety themes.
- **Cross-site comparison:** We developed a cross-site 'traffic light' assessment across the identified safety themes based on reported strengths, gaps, or areas to maintain/re-enforce.
- **Triangulating to objective data:** We triangulated the qualitative insights from PSW with **objective safety and satisfaction metrics** collected via the hospital scorecards to identify convergent trends and areas for system-level improvement.
- **Identifying actionable measures:** We identified recurrent areas for improvement and grouped them according to where action is taken: Executive level, local level, and broader community level.

## 4. RESULTS

### 4.1 PSW activity responses

A total of **184 responses** were received across the five participating hospitals. [Figure 2](#) shows the distribution across sites. Feedback captured a diversity of voices, ranging from clinicians to patients and operational/security staff ([Figure 3](#)).

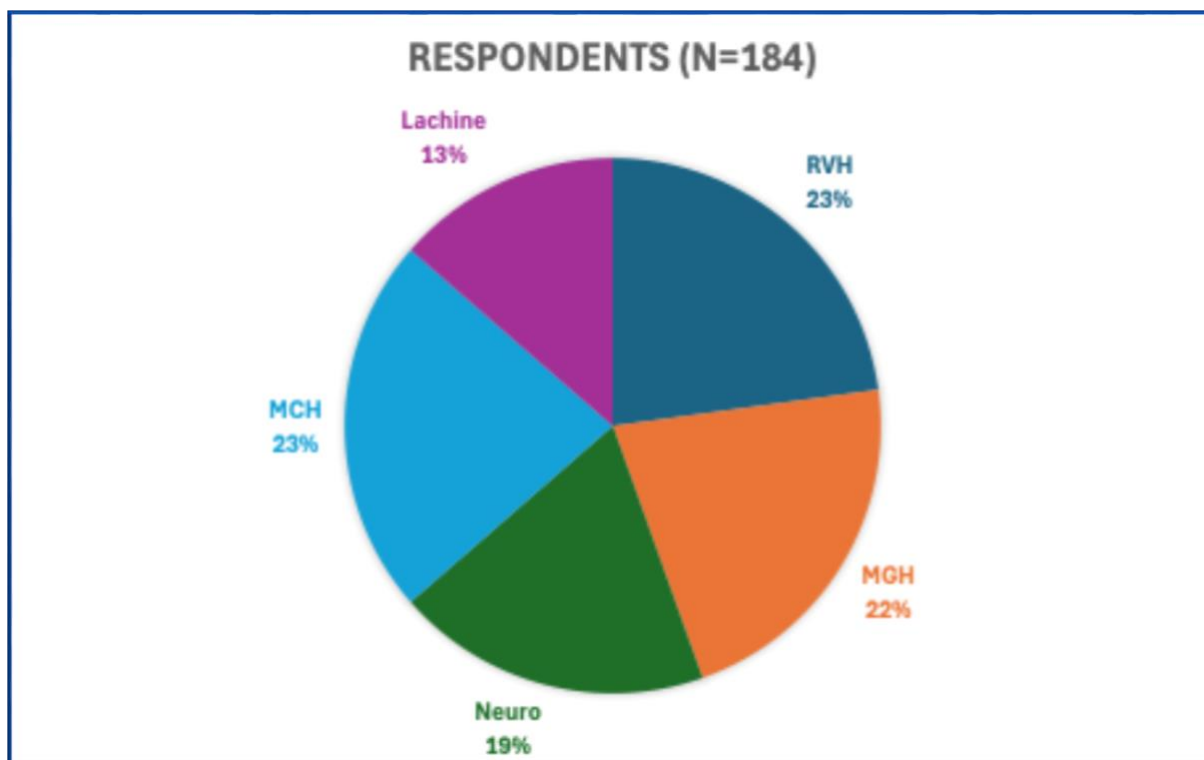


Figure 2. Distribution of feedback across the 5 MUHC sites

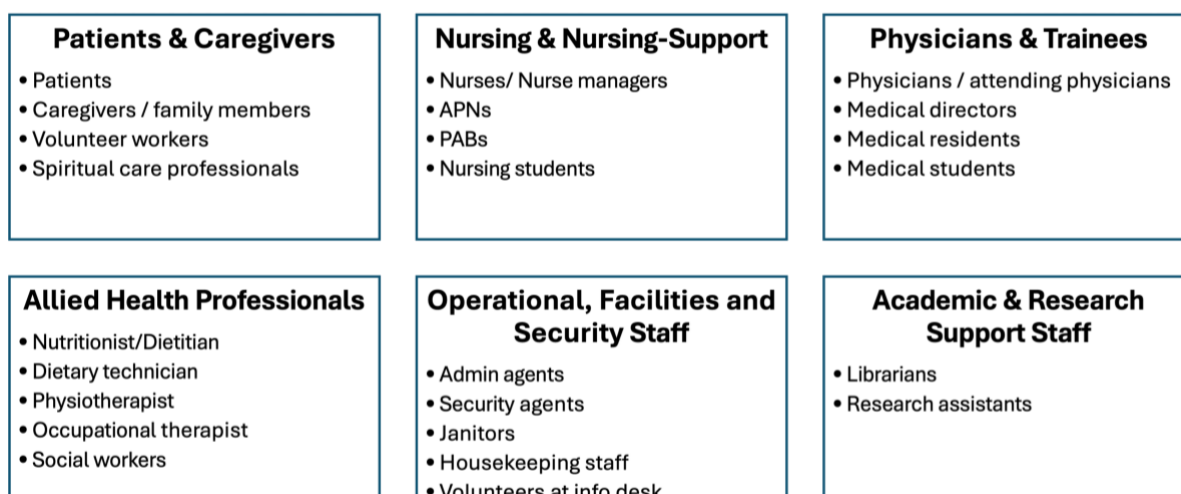


Figure 3. MUHC voices represented

## 4.2 Grouping by perceived performance

For each site, feedback received was reviewed by two analysts and grouped into three key categories:

1. **Perceived strengths:** Comments by participants that describe observed safety behaviours or moments such as "I see x... or I take time to do y... or any positive statement;
2. **Perceived areas to maintain or reinforce:** Comments by participants with a conditional tone such as "... when actively involving patient... or any action related to accreditation themes";
3. **Perceived gaps:** Comments by participants such as "I wish for x... or should have more y... or increase z".

Appendix [Table A-1](#) illustrates an example from one of the sites.

## 4.3 Qualitative thematic analysis

The following global safety themes emerged from our analysis:

1. **Patient-Centered Communication & Engagement:** communication, empathy, patient/family involvement;
2. **Safety Practices & Culture:** safe behaviours, double checks, infection prevention, incident reporting;
3. **Teamwork & Collaboration:** inter- and intra-professional coordination;
4. **Workforce & Systems Readiness:** staffing adequacy, workflows, training, support;
5. **Safe Environment & Equipment:** physical space, cleanliness, equipment availability;
6. **Care Transitions:** inter-department and inter-site coordination, discharge and follow-up.

These 6 themes mapped clearly to established Accreditation Canada ROPs ([Figure 4](#)).

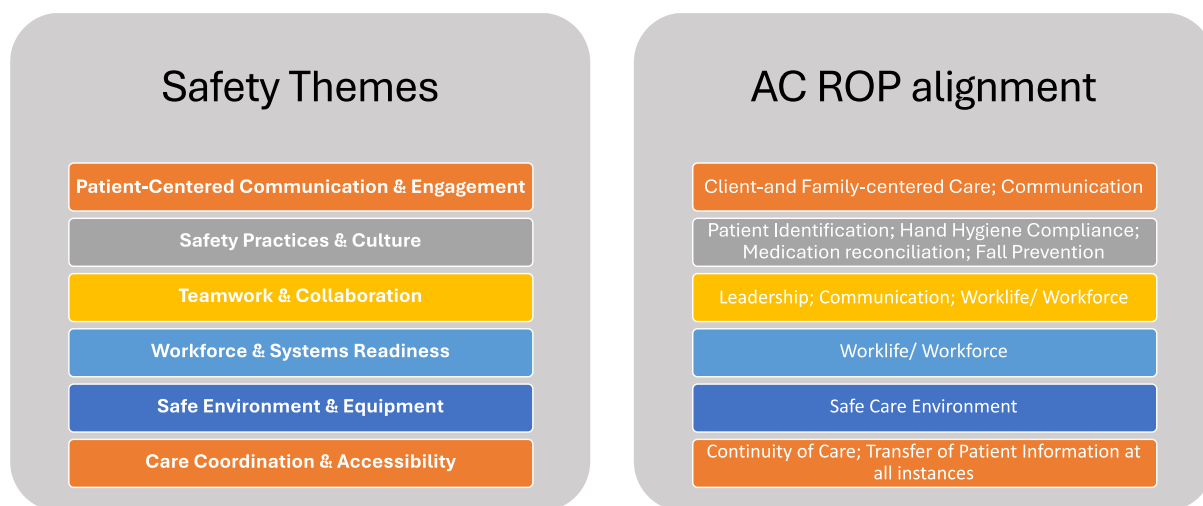


Figure 4. Mapping identified safety themes to Accreditation Canada Required Organizational Practices (ROP)

### 4.4 Cross-site comparison

To obtain a cross-site comparative snapshot of observed strengths or areas for improvement, we mapped the six identified safety themes against reported areas of strength (green), maintenance (yellow) or improvement (red), using a “traffic light” framework, shown in [Figure 5](#).

Safety Theme	AC standards/ROP alignment	Site A	Site B	Site C	Site D	Site E
<b>Patient-Centered Communication &amp; Engagement</b>	-Client-and Family-centered Care -Communication	●	●	●	●	●
<b>Safety Practices &amp; Culture</b>	-Incidents and Accidents Management -Patient Identification -Patient Safety Training -Hand-Hygiene Compliance -Medication reconciliation at care transitions -Fall Prevention	●	●	●	●	●
<b>Teamwork &amp; Collaboration</b>	-Leadership -Communication -Worklife/ Workforce	●	●	●	●	●
<b>Workforce &amp; Systems Readiness</b>	-Worklife/ Workforce	●	●	●	●	●
<b>Safe Environment &amp; Equipment</b>	-Safe Care Environment	●	●	●	●	●
<b>Care Coordination &amp; Accessibility</b>	-Continuity of Care -Transfer of Patient Information at all instances	●	●	●	●	●

● = Perceived strengths reflected in safety behaviors (already practiced & valued)  
● = Perceived areas to maintain or reinforce  
● = Perceived areas for improvement

Figure 5. Cross-Site Comparative Snapshot on Perceptions of Safety (5 Sites; n=184)

#### 4.4.1 Common Strengths

- **Communication & Engagement** were a consistent strength (green across all sites), representing a shared culture of empathy and patient inclusion.
- **Teamwork & Collaboration** were also strong across all sites.

#### 4.4.2 Areas to Maintain/Reinforce

- **Safety Practices & Culture** are stable, especially knowledge about hand hygiene, double identification and medication checks, but feedback indicates a need for ongoing attention and reinforcement to counter environmental & workload pressures.

#### 4.4.3 Areas for Improvement (gaps)

- **Workforce & Systems Readiness** are the most common weaknesses, indicating systemic resource and process challenges across the network (e.g. electronic health record, staffing shortages).
- **Physical Environment & Equipment** issues are widespread (red across all sites), reflecting aging infrastructure and accessibility limitations.
- **Care Transitions:** Accessibility issues, booking communication and care coordination with external providers require improvement across sites; digital tools could help.

### 4.5 Triangulation with objective data (preliminary)

- In the next step of our analysis, we sought to determine whether *qualitative perceptions* (color-coded from the Patient Safety Week feedback) align or conflict with *quantitative indicators* (from hospital scorecard measures and satisfaction surveys etc.).
- The perceived strengths/gaps reported during PSW are broadly consistent with the objective data, which validates that staff and patient perceptions are largely grounded in real experience ([Table 1](#)).

#### 4.5.1 Areas of alignment

- **Patient-Centered Communication & Engagement:** Data from large annual patient satisfaction surveys align with perceptions from PSW participants, indicating a strong culture of patient engagement and empathy.
- **Safety Practices & Culture:** Sites with stronger hand hygiene (e.g. Site E) also received “green” perception ratings for safety behaviours and culture, while others received ‘yellow’ ratings indicating need for reinforcing these behaviours.

- **Safe Environment & Equipment:** Cleanliness satisfaction, obtained from large satisfaction surveys, is low across all sites (37–60%), mirroring red perceptions in feedback (clutter, maintenance, signage). This indicates that environment quality is a visible, shared concern.
- **Care Coordination & Accessibility:** Coordination and internal communication satisfaction are generally low (46–64%), matching qualitative feedback about care transitions and inter-site communication issues, thus confirming that systemic coordination is a network-wide challenge.

#### 4.5.2 Areas of partial or mixed alignment

- **Shared decision-making:** Results from large patient satisfaction surveys indicate low satisfaction (53–63%) regarding shared decision-making, which was not reflected in the PSW feedback.
- **Safety Practices & Culture:** Sites with objective measures of low hand-hygiene compliance or high fall rates received yellow perceptions, suggesting that participants are aware that certain safety behaviours need reinforcement but may not be aware of objective safety metrics.

**Table 1. Triangulating qualitative feedback with objective measures**

Safety Theme	Objective Metric	Site A	Site B	Site C	Site D	Site E
<b>Patient-Centered Communication &amp; Engagement</b>	Pt satisfaction survey 2024-25: communication with doctors	77% (n=621)	76% (n=195)	72% (=302)	75% (n=28)	
	Pt satisfaction survey 2024-25: communication with nurses	74%	71%	73%	54% (n=28)	
	Pt satisfaction survey 2024-25: shared decision-making	63%	58%	57%	53%	
<b>Safety Practices &amp; Culture</b>	C. Diff Infections per 100,000 (2024-25)	5.4	0.5	5.4	2.1	4.0
	Hand hygiene compliance		66%		74%	80% (2023)
	Falls w/ consequences (2024-25) (falls/pt-days*1000)	0.7	0.9	1.8	3.1	
<b>Workforce &amp; Systems Readiness</b>	6-month retention rate	89% (2023)	86%	83%	82%	88%
<b>Safe Environment &amp; Equipment</b>	Pt satisfaction survey 2024-25: cleanliness	60%	37%	47%	46%	
<b>Care Coordination &amp; Accessibility</b>	Pt satisfaction survey 2024-25: coordination of tests/procedures	59%	60%	64%	58%	
	Pt satisfaction 2024-25: internal coordination of care	52%	56%	52%	46%	
	Pt satisfaction 2024-25: discharge planning	77%	79%	77%	73%	

Quantitative numbers reported in each cell correspond to objectively collected data, while cell colours refer to PSW feedback

## 5. TURNING INSIGHTS INTO ACTION

### 5.1 Identifying areas for improvement

Four priority areas for improvement were identified based on recurring feedback received across sites.

1. **Physical environment: Accessibility**
  - Improve access for reduced mobility and elderly patients: ramps, front entrance access, automatic doors, salt on sidewalks
2. **Physical environment: Cleanliness**
  - Reduce clutter in shared spaces and patient areas
3. **Equipment investment**
  - Invest in equipment such as wheelchairs and medication barcode scanners
4. **Safety practices/Just culture**
  - Reinforce safety practices like hand hygiene, falls prevention, medication safety for patients & staff
  - Provide culturally safe care, particularly for our indigenous patients

### 5.2 Grouping action by jurisdiction

We mapped the identified areas for improvement to three jurisdictions for action, based on *who* can act on the feedback:

1. **Executive-level actions:** Operational, cultural, or structural improvements requiring strategic direction or investment, aimed at senior leadership.
2. **Local managerial actions:** Unit-based workflow, staffing, and practice improvements, aimed at local leadership and daily operations.
3. **Broader community actions:** Sensitization messages for patients, caregivers and community partners on safety behaviors and environmental factors.

[Table 2](#) displays each area of improvement and the level of action needed.

**Table 2. Priority themes by jurisdiction**

Safety Theme	Executive Level	Local unit level	Broader community (Messaging to Patients and Frontline staff)
<b>Physical environment: Accessibility</b>	Improve access for reduced mobility and elderly patients: ramps, front entrance access, automatic doors, salt on sidewalks	<ul style="list-style-type: none"> <li>•<b>Site A:</b> Accessibility Committee recommendations</li> <li>•<b>Site B:</b> icy sidewalks in winter, ramps, doors</li> <li>•<b>Sites C, E:</b> Improve signage and directions</li> </ul>	<ul style="list-style-type: none"> <li>•Reinforce communication re: appointments, parking, directions</li> <li>•Use Patient Safety Champions</li> <li>•Client safety educational materials</li> </ul>
<b>Physical environment: Cleanliness</b> <i>Create a worklife and physical environment that supports the safe delivery of care/service.</i>	Reduce clutter in shared spaces and patient areas	<ul style="list-style-type: none"> <li>•<b>Sites B, C:</b> Declutter patient rooms, hallways</li> <li>•<b>Site A:</b> Improve cleanliness of shared spaces</li> </ul>	<ul style="list-style-type: none"> <li>•Reinforce safety practices like proper wheelchair positioning,</li> <li>•Use Patient Safety Champions</li> </ul>
<b>Equipment investment</b>	Wheelchairs, medication barcode scanners	<ul style="list-style-type: none"> <li>•Determine local needs</li> </ul>	
<b>Safety practices/Just culture:</b> <i>Create a culture of safety within the organization</i>	Provide culturally safe care	<ul style="list-style-type: none"> <li>•<b>Site D:</b> Appropriate nutrition for older patients</li> <li>• <b>Site D:</b> Falls prevention: Appropriate training for restraint use</li> </ul>	<ul style="list-style-type: none"> <li>•Client and family role in safety: Reinforce safety practices like hand hygiene, falls prevention, medication safety for patients &amp; staff</li> <li>•Use Patient Safety Champions</li> <li>•Client safety educational materials</li> </ul>

## 6. LIMITATIONS AND CONSIDERATIONS

### 6.1 Limitations

- There is the potential for selection bias because responses represent the views of those who chose to participate, not a random or representative sample.
- Results should be interpreted as *perceptions* rather than empirical measurement.
- The feedback provides valuable insight into lived experience but not statistical proof of site performance.

## 6.2 Strengths

- The identified themes were well aligned with Accreditation Canada ROP domains, indicating conceptual validity.
- We triangulated qualitative insights with objective data (e.g., patient satisfaction, hand hygiene, safety culture) as an additional validity check.

## 7. CONCLUSIONS

- This cross-site Patient Safety Week initiative successfully demonstrates how structured engagement with patients, families, and frontline staff can serve as a strategic organizational learning mechanism.
- By systematically capturing and analyzing 184 narrative responses across five MUHC sites, this initiative intended to generate value by translating insights into actionable safety data aligned with Accreditation Canada Required Organizational Practices (ROPs).
- Our findings reveal that the MUHC has a strong cultural foundation in communication and teamwork, but also system-level challenges related to infrastructure, and coordination.
- The consistency of themes across sites, and their alignment with objective data, supports the validity of frontline and patient perspectives as a critical complement to traditional performance metrics.
- By transforming narrative feedback into structured insights, this initiative operationalizes the principles of a **Learning Health System**, whereby data generated in routine care are transformed into knowledge and reintegrated into decision-making processes. It highlights the potential of Patient Safety Week to function not only as an engagement activity, but as a repeatable, low-cost learning cycle that strengthens the MUHC's capacity for responsiveness, shared accountability, and continuous improvement.

## 8. RECOMMENDATIONS

Based on the findings of this analysis, the following recommendations are proposed:

### 8.1 Institutionalize Patient Safety Week as a learning cycle

- Formalize PSW as an annual organizational learning intervention, with standardized processes for data collection, analysis, and reporting.
- Ensure findings are systematically fed into governance structures, quality committees, and strategic planning processes to complete the feedback loop.

### 8.2 Reinforce safety practices and Just Culture

- Sustain and strengthen core safety behaviours (e.g., hand hygiene, double identification, medication safety) through ongoing education and reinforcement.
- Promote a just culture by encouraging speaking up, near-miss reporting, and shared accountability across all levels of the organization.

### 8.3 Engage local-level levers to implement improvements

- Empower local managers to implement unit-level improvements (e.g., decluttering, signage, workflow optimization, mobility support).
- Engage patients, families, and volunteers through targeted safety awareness campaigns (e.g., falls prevention, identification checks, communication).

### 8.4 Advance data valorization and measurement

- Continue triangulating qualitative feedback with quantitative indicators to validate findings and monitor impact.
- Develop key performance indicators (KPIs) and key behavioural indicators (KBIs) linked to identified priorities (e.g., accessibility, coordination, responsiveness).

### 8.5 Close the Feedback Loop

- Communicate results and resulting actions back to staff and patients to reinforce trust, engagement, and transparency.
- Demonstrate how feedback leads to tangible improvements, thereby strengthening participation in future initiatives.

**APPENDICES**

**APPENDIX A: GROUPING BY PERCEIVED PERFORMANCE**

**Table A-1. Feedback (n=42) from one MUHC site grouped according to perceived strengths, gaps and areas to maintain/reinforce**

Perceived Strengths	Areas to Reinforce or Maintain	Areas for Improvement
<ul style="list-style-type: none"> <li>• Specialists and families involve in multidisciplinary rounds</li> <li>• Cases discuss regularly</li> <li>• Clear communication amongst staff</li> <li>• Colleagues support each other and share reminders</li> <li>• Procedures/treatments explain in understandable terms</li> <li>• Information and guidance provided to families</li> <li>• Post-discharge contact (reconnect line) provided</li> <li>• Patients encourage to express concerns</li> <li>• Report adverse events without hesitation</li> <li>• Use checklists during procedures</li> <li>• Patient needs are verified before procedures</li> <li>• Patients are assisted with mobility</li> <li>• Empathy</li> <li>• Having access to reporting measures</li> </ul>	<ul style="list-style-type: none"> <li>• Consulting pharmacy</li> <li>• Double-checking doses before administration</li> <li>• Verifying with patient and family if medication is appropriate</li> <li>• Listening and involving patients in decisions about their care</li> <li>• Providing teaching to families</li> <li>• Washing hands before and after care</li> <li>• Raising bed rails</li> <li>• Promoting awareness and share best practices</li> <li>• Supporting mental health care for staff</li> </ul>	<ul style="list-style-type: none"> <li>• Increase multidisciplinary meetings</li> <li>• Increase staff for wheelchair support</li> <li>• Encourage patients to wash their hands</li> <li>• Improve signage and room directions</li> <li>• Put all the monitors on the same side of the patients' bed in ICU</li> <li>• Soundproof noisy play area and reduce safety risks with glass window on balcony of A.RC 4227</li> <li>• Increase continuous training</li> <li>• Implement alarm bracelets for allergies</li> </ul>