PHSA Patient Safety Event Reviews

Framework for Patient and Family Partner Participation

PILOT

Provincial Health Services Authority

Quality, Practice & Clinical Informatics

Fall 2025

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

Table of contents

Land acknowledgement . . . 3

About this framework . . . 4

Background

Why is patient and family partner participation important for patient safety event reviews? . . . 5

Key terms . . . 6

Partnering in patient safety event reviews: Key steps . . . 7

PART A: Create an environment for partnership

Step 1: Initiate — Engagement readiness and team preparation . . . 9

Step 2: Plan — Engagement objectives, role clarity and training . . . 11

PART B: Engage and enable committee members

Step 3: Partner — Finding and inviting patient and family partners . . . 14

Step 4: Connect — Welcome and support patient and family partners . . . 15

PART C: Implement and sustain change — embed patient and family partner roles

Step 5: Involve — Facilitate the participation of patient and family partners in review committee meetings . . . 17

Step 6: Conclude — Close the loop and evaluate . . . 18

Definitions . . . 19

Appendices

Appendix A: Roles & responsibilities . . . 20

Appendix B: FAQs . . . 24

Appendix C: Process for patient & family partner participation in patient safety event reviews . . . 25

Appendix D: Patient safety event review: Process overview . . . 27

References . . . 28

Thank you

A heartfelt thank you to our colleagues across PHSA programs and services, for sharing your insights, thoughtful edits, and invaluable contributions to shape this framework. Your input has been instrumental in making this document meaningful and impactful.

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Pilot framework

Please note, through the pilot phase, resources referenced in this framework will be available on a shared drive: Patient & Family Partner Participation in PSERs.

To request access, please contact pfp@phsa.ca

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

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), Sḵwx̱wú7mesh (Squamish Nation) and səl̓ílwətaɬ (Tsleil-waututh Nation) on whose unceded and ancestral territory our head office is located.

Land acknowledgement
About this framework
Background
PART A: Create an environment for partnership
PART B: Engage and enable committee members
PART C: Implement and sustain change
Definitions
Appendices
References

About this framework

This framework offers guidance on how to collaborate effectively and safely with patient and family partners on patient safety event reviews (PSERs).

The framework outlines:

- Why we include patient and family partners in patient safety event reviews
- How we train and support staff and patient and family partners to work together on review committees
- Practical steps and tools for including patient and family partners in safety reviews

Who is this framework for?

This framework is for staff, health care professionals, and patient and family partners within PHSA programs and services involved in patient safety event review committees. Each committee member plays an important role in identifying system gaps, fostering learning, and minimizing the risk of harm to patients.

This document should be used alongside existing PSER process tools, templates, resources, and the PSER protocol.

This framework draws on leading practices from provincial and international sources and is adaptable to various PHSA programs and services.

Patient partners at the BC Mental Health and Substance Use UNITE event, 2023

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

Why is patient and family partner participation important for patient safety event reviews?

Key terms

Partnering in patient safety event reviews: Key steps

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

Background

Why is patient and family partner participation important for patient safety event reviews?

Person- and family-centred care is a priority across the health system. It is widely acknowledged that involving patients and families in health care decisions — including those about patient care, hospital procedures, and policies — leads to better health outcomes, higher quality of care, reduced costs, improved patient experience, and enhanced patient safety.[1, 2, 3, 4] Their insights are especially relevant in patient safety event reviews, where diverse perspectives can help uncover root causes and deepen understanding of safety events.[5] Patient and family partners act as "knowledge brokers," bringing lived experience and a system-wide perspective.[6] Their contributions highlight areas for improvement that might otherwise go unnoticed, driving meaningful learning and stronger safety solutions. Integrating patient voices at all levels fosters a culture of transparency, trust, and collaboration, ensuring patient safety remains a priority.[7] When fully included as members of patient safety event review teams, patient and family partners bring the patient and family perspective, strengthening patient-centred approaches in every aspect of the process.

At PHSA, involving patient and family partners in safety event reviews aligns with our commitment to person-centred partnerships and a culture of patient safety. Our updated PSER process, accreditation requirements, and commitment to advancing person-centred care underscore the importance of integrating patient and family partners in this work. Adequate resources and a standardized approach are essential to ensure patient and family partners can contribute effectively and safely to review committees. This broadens the range of perspectives and knowledge systems that inform care delivery.

Patient partners at the BC Mental Health and Substance Use UNITE event, 2023

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

Why is patient and family partner participation important for patient safety event reviews?

Key terms

Partnering in patient safety event reviews: Key steps

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

Key terms

Patient:

An individual who has, does, or might receive health care services. May also be referred to as **client**, **service user**, **resident**, **care seeker**, or **community member**.

Family:

Individuals related by biology, kinship, legal ties, or deep personal connection. This includes caregivers, essential care partners, and chosen family — anyone who provides physical, emotional, or psychological support to the patient. Family is defined by the patient and can include anyone the patient designates as significant in their care journey.

Patient and family partners:

Any patient or family member who participates in engagement opportunities to bring a patient/family perspective to health system and services initiatives. They represent the perspectives of the people we serve.

Health care partners:

Staff members who seek to include patient and family partner perspectives in projects. We use the term **partner** to emphasize collaboration rather than a provider/recipient relationship.

Patient safety event:

An event that results in unintended harm to the patient and is related to the care or services provided rather than the patient's underlying condition. Harm also includes Indigenous-specific* racism, discrimination, racial or gender-based biases, or psychological, emotional, or spiritual harm.

Comprehensive (patient safety event) review:

Previously called **quality review**, this is an incident analysis method for events with a higher degree of harm (levels 3–5), usually requiring significant time and resources. This framework applies to these types of reviews.

**Events involving Indigenous-specific racism and discrimination are out of scope for this framework.*

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

- Why is patient and family partner participation important for patient safety event reviews?
- Key terms
- Partnering in patient safety event reviews: Key steps

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

Partnering in patient safety event reviews: Key steps

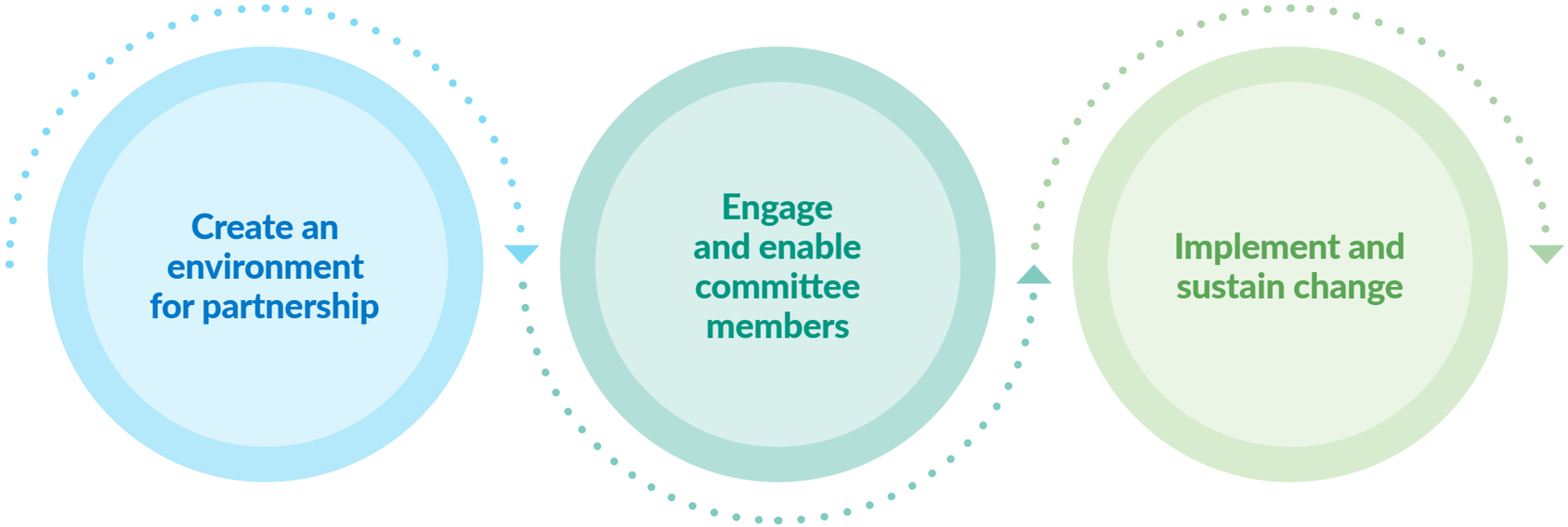
This framework is divided into three sections that align with each stage of the PHSA patient and family engagement process:

PART A: Create an environment for partnership
Initiate and plan

PART B: Engage and enable committee members
Partner and connect

PART C: Implement and sustain change — embed patient and family partner roles
Involve and conclude

Meaningful engagement involves careful planning, regular check-ins, follow-through, and proper closure. The following steps will guide you in collaborating with patient and family partners on review committees.



PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

- **Step 1: Initiate —** Engagement readiness and team preparation
- **Step 2: Plan —** Engagement objectives, role clarity and training

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

PART A: Create an environment for partnership

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

Step 1: Initiate —
Engagement readiness and team preparation

Step 2: Plan —
Engagement objectives, role clarity and training

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

Step 1: Initiate

Engagement readiness and team preparation

Programs are encouraged to recruit and welcome a small group of patient and family partners to participate in PSERs for a defined term. However, before inviting them to take part, staff must first complete key steps to ensure an environment that is prepared and supportive of meaningful engagement.

1.1 Identify staff members to lead the work:

- Who will recruit, welcome, and support patient and family partners? (e.g., Quality & Safety Manager, Patient Experience Leader)
- Are there funds to offer honoraria and reimburse expenses? Account for onboarding, training, and review participation.
- Ensure you know the payment and reimbursement process.
- Is leadership supportive and prepared to champion this change? (e.g., medical, quality and safety, risk, patient experience, operations)

Sample budget:

Activity	Time (approx)	Honoraria rate	# of PFPs	Frequency	Subtotal (per PFP)	Total for group
Training	11 hours	$30/hour	5	One-time payment — when onboarding new PFP pool	$330	$1,650
Review participation	5 hours	$30/hour	2	Per review	$150	$300 (per pair)

Leadership and organizational support are essential. Safe and meaningful engagement begins with acknowledging the significance of this work across all decision-making levels in the health care system.

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

Step 1: Initiate —
Engagement readiness and team preparation

Step 2: Plan —
Engagement objectives, role clarity and training

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

Step 1: Initiate

Engagement readiness and team preparation

1.2 Bring core committee members together to discuss patient and family partner participation in PSERs:

- Develop a clear understanding of the goals, objectives, and overall readiness for patient and family partner involvement.
- Clarify why and how patient and family partners will support patient safety event reviews:
  - What is the value of including patient and family partners on review committees?
  - Why are we doing this now?
  - How will this impact patients?
  - How will this impact staff?

Taking the time to understand the value of including patient and family partners, addressing concerns, and considering the risks of maintaining the status quo sets a strong foundation for collaboration.

Support

Patient and family partners and staff may need support during the patient safety event review process. Aim to provide equitable support for both patient and family partners and staff, including resources such as mental health services, occupational health programs, or peer support initiatives. Engaging in patient safety event reviews can be emotionally demanding, so staff and patient and family partners should have clearly communicated support options (e.g., direct line managers, community services, peer support, mental health first aid).

Resource documents

- Staff readiness for patient engagement conversation prompts
- FAQs
- Roles & responsibilities
- Beyond Grateful Playbook: Recognition, Expenses and Honorariums for Patient & Family Engagement at PHSA
- PFP Honorarium Guidance (POD)
- Psychological Health & Safety: Working Well Resources for Leaders (Staff support resources on POD)
- UBCLC Counselling Support | UBC Learning Circle (Patient and family partner support resources — publicly accessible)

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

Step 1: Initiate —
Engagement readiness and team preparation

Step 2: Plan —
Engagement objectives, role clarity and training

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

Step 2: Plan — Engagement objectives, role clarity and training

Familiarize yourself with the engagement objectives, roles, levels and methods of engagement outlined below. Bring core committee members together to discuss as a group.

2.1 Review goals and objectives for involving patient and family partners in reviews.

- Outline how the patient and family partners will participate.
- Clear communication of these expectations helps avoid tokenism.

2.2 Understand when and how patient and family partners will be involved:

- Purpose of engaging patients and families in reviews:
  - Bring lived experience and system-wide understanding.
  - Identify hidden areas for improvement.
  - Drive meaningful learning and robust safety solutions.
  - Provide unique perspectives to deepen understanding of safety events and root causes.
- Confirm how their input will feed into the review process (e.g., as full members of the review committee).

2.3 Discuss level and method of engagement:

- This initiative is at the **involve** or **collaborate** level.
  - **Involve:** embed partner insights and perspectives
  - **Collaborate:** collaborate with partners and commit to shared decision making
- Be transparent about the level of influence partners will have on recommendations.

2.4 Clarify roles:

- What is the patient/family partner's role? (Refer to PSER review committee roles and responsibilities).
- What is the time commitment? (See sample schedule on the next page)

2.5 Review the education plan and prepare a support plan:

- Confirm you have the learning materials.
- Identify the main contact for patient and family partners.
- Clarify available supports for patient and family partners.

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

Step 1: Initiate —
Engagement readiness and team preparation

Step 2: Plan —
Engagement objectives, role clarity and training

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

References

Step 2: Plan — Engagement objectives, role clarity and training

Develop a schedule that outlines onboarding, review activities, known dates and estimated time commitment. This can support early resource planning and ensures clear communication of expectations when engaging potential patient and family partners.

Sample schedule:

Patient & family partner activity	Approx. time (hrs)	Description
Recruitment and training *(one-time payment when onboarded)*		
Intro, onboarding & orientation	1.0 – 1.5	Timing may vary based on group size
Self-directed learning	1.5 – 2.5	Learning Hub courses + pre-reading
Training (part 1 & part 2)	4.0	Interactive sessions
Additional training (part 3)	1.5 – 3.0	Written feedback, 1.5 hrs/review
Approximately 8.0 – 11.0hrs max per patient/family partner. Maximum hours should be confirmed with partners in advance.		
Review committee participation *(recurring payments for each review)*		
Check in / readiness meetings		
Reviewing PSER package	1.0	Reading materials prior to meeting
Review meeting(s)	1.5 – 3.0	Typically, 1.5-hour sessions
Debrief activities	0.5 – 1.5	Check-in call / post-review survey
Hours will vary depending on review meetings. Where possible, maximum hours should be confirmed with partners in advance to help manage expectations.		

Resource documents

- Roles and responsibilities
- Facilitating Trauma-Informed Meetings (Learning Hub course)
- TIP Meeting Facilitation Toolkit
- Education plan
- FAQs

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

Step 3: Partner —
Finding and inviting patient and family partners

Step 4: Connect —
Welcome and support patient and family partners

PART C: Implement and sustain change

Definitions

Appendices

References

PART B: Engage and enable committee members

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

Step 3: Partner —
Finding and inviting patient and family partners

Step 4: Connect —
Welcome and support patient and family partners

PART C: Implement and sustain change

Definitions

Appendices

References

Step 3: Partner — Finding and inviting patient and family partners

3.1 Identify who you need to engage:

- Aim to recruit 5–10 patient and family partners for your program or service. Expanding the group of partners helps ensure greater diversity in lived experience, perspectives, and availability — strengthening representation and flexibility when meetings are convened.
- Choose individuals with experience in quality improvement who can commit to a one to two-year term.
- Consider unique barriers they may face, and proactively include marginalized voices to ensure diverse backgrounds and perspectives.

3.2 Ensure accessibility and equity:

- How can you make participation more accessible (interpretation services, offer tech support, providing clear instructions, etc)?
- Reduce financial, emotional, and logistical barriers to participation.

3.3 Draft an engagement invitation to outline your request:

- Use clear language; avoid acronyms and jargon.
- See the engagement invitation template.

3.4 Invite participation:

- Collaborate with your program's Patient Engagement/ Experience department.
- Consider the Patient Voices Network (a provincial network of patient and family partners, administered by Health Quality BC).

3.5 Complete a selection process:

- Decide on your selection method (e.g., interview, meet and greet).
- It's recommended to involve a Patient Experience lead.
- Offer an initial meet/greet to answer questions, set expectations and ensure a good fit.
- Select applicants for PFP pool. Be sure to send a gracious communication to all patient and family partners who may have expressed interest in participating, to share the outcome of your decision, either way.

Resource documents

- Patient & family partner engagement invitation template
- Patient & family partner selection tools
- Provincial Language Services

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

Step 3: Partner —
Finding and inviting patient and family partners

Step 4: Connect —
Welcome and support patient and family partners

PART C: Implement and sustain change

Definitions

Appendices

References

Step 4: Connect

Welcome and support patient and family partners

This phase emphasizes making patient and family partners feel welcomed, prepared, and supported throughout patient safety event reviews.

4.1 Host a welcome meeting (orientation and onboarding):

- Schedule a group orientation session to bring everyone together and get to know each other.
- Clarify the scope of their role and explain how their input will be used.
- Review team roles and responsibilities and identify their primary contact person.
- Provide opportunities for questions and discussion.
- Discuss honoraria and reimbursement processes and ask how they'd like their contributions recognized.
- Agree on communication preferences.
- Ask about accessibility needs or additional supports.
- Explain the requirements and processes for confidentiality agreements and privacy.
- Set up Learning Hub access (PHSA affiliate account).

4.2 Schedule and support partners to complete training:

- Review the education plan and logistics.
- Schedule and deliver training sessions (see education plan).

Resource documents

- Onboarding checklist and orientation package
- Patient and family partner agreement form
- Confidentiality form
- Education plan
- Patient safety event reviews (tools, templates, resources)
- Patient safety event review protocol
- Criteria for PFP involvement in PSER committee
- PHSA Patient and Family Engagement Framework
- Beyond Grateful Playbook: Recognition, Expenses and Honorariums for Patient & Family Engagement at PHSA
- PFP Honorarium Guidance (POD)

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Step 5: Involve —
Facilitate the participation of patient and family partners in review committee meetings

Step 6: Conclude —
Close the loop and evaluate

Definitions

Appendices

References

PART C: Implement and sustain change — embed patient and family partner roles

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Step 5: Involve —
Facilitate the participation of patient and family partners in review committee meetings

Step 6: Conclude —
Close the loop and evaluate

Definitions

Appendices

References

Step 5: Involve

Facilitate the participation of patient and family partners in review committee meetings

This phase focuses on ensuring patient and family partners can effectively participate in committee meetings and that their feedback is incorporated into recommendations.

5.1 Involve patient and family partners in review committee meetings:

- Use the criteria for PFP involvement in PSER committee to decide if a review can include patient and family partners.
- Share upcoming review details with the patient and family partner pool:
  - High-level description of the event,
  - Review committee meeting dates and times,
  - Names of care team members involved in the event.
- Include the criteria for PFP involvement in PSER committee sheet so patient and family partners know when to recuse themselves if needed.
- If multiple partners are available/interested, invite two partners to participate. This helps provide peer support and heightened psychological safety for the patient and family partners.
- Use the "review kick-off" checklist to confirm readiness.
- Provide access to the documentation members need to review before the meeting (e.g. link to Teamsite) and resources to support PFP involvement (e.g., roles & responsibilities, FAQs, meeting invites).
- Confirm that support systems are in place.

5.2 Listen to and integrate feedback:

- Ensure the facilitator is well-versed in trauma-informed facilitation.
- Reflect on their perspectives, advice, and recommendations and act on them as appropriate.

5.3 Issue honoraria and reimburse expenses promptly.

5.4 Check in regularly:

- Follow up after the initial meeting to learn about their experience.
- Agree on how and when you'll continue checking in.
- Adjust as needed.

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Step 5: Involve —
Facilitate the participation of patient and family partners in review committee meetings

Step 6: Conclude —
Close the loop and evaluate

Definitions

Appendices

References

Step 6: Conclude

Close the loop and evaluate

6.1 Debrief and evaluate consistently:

- Follow up with patient and family partners about their experience.
- Discuss how patient/family ideas influenced the process and recommendations.
- Check in regularly to identify improvement opportunities.
- Discuss challenges and develop action plans.
- Send out an evaluation survey at the end of each review.
- Report findings to leadership to show impact and gather support for expansion.

6.2 Close the loop:

- Formally recognize the end of the review and offer appreciation for their contributions.
- Include patient and family partners in any CTL post review communications sent to the committee members, i.e., learning summary.

Key components

- Appreciation — recognize patient and family partners' contributions.
- Review process — share how feedback shaped the review, and any lessons learned.
- Review outcome — share learning summary.

Evaluation considerations

- Send a post-review survey to committee members.
- Collect qualitative feedback in debrief sessions.

Resource documents

- Post PSER survey
- Patient & family partner 1:1 check ins

Land acknowledgement
About this framework
Background
PART A: Create an environment for partnership
PART B: Engage and enable committee members
PART C: Implement and sustain change
Definitions
Appendices
References

Definitions

Concise (patient safety event) review:

Previously called PSLS Review/Routine Review. An incident analysis method for events with lower harm (levels 1–3 or near-misses) suited to local evaluation with fewer resources.

Comprehensive (patient safety event) review:

Previously called Quality Review. Used for higher-harm events (levels 3–5) requiring significant time and resources.

Critical comprehensive (patient safety event) review:

Previously called Critical Patient Safety Event Review (CPSER). Uses the Comprehensive Review method for incident analysis and may require reporting to the PHSA Q&S Board Committee and BCEHS Board.

Engagement:

An initiative, event, or process where patient and family partners contribute lived experience to inform, design, and/or evaluate health services.

Expense:

Costs related to an activity that can be compensated, e.g., travel or childcare.

Family:

Individuals related by biology, kinship, legal ties, or deep personal connection.

Health care partner:

Staff members seeking to include patient and family partner perspectives in projects.

Honorariums:

Payments made to show appreciation for time, expertise, and lived/living experience. Often given to volunteers, patient and family partners, and community members.

Multi-agency review:

A collaborative patient safety event review involving multiple health authorities, using the comprehensive review analysis to address complex issues.

Multi-program review:

A collaborative patient safety event review involving multiple PHSA programs, also using the comprehensive review approach.

Patient and family-centred care:

An organizational culture that arranges care around patient/family needs rather than system needs.

Patient and family partners:

Individuals bringing the patient/family perspective to health services initiatives.

Reimbursement:

Repaying out-of-pocket expenses incurred by patient and family partners.

Trauma-informed practice:

A strengths-based approach recognizing the impact of trauma, emphasizing safety, and creating opportunities for control and empowerment.

Refer to the PSER glossary of terms and definitions for additional details.

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

Appendix A: Roles & responsibilities

Appendix B: FAQs

Appendix C: Process for patient & family participation in patient safety event reviews

Appendix D: Patient safety event review: Process overview

References

Appendix A

Roles & responsibilities

Patient & family partner (PFP) participation in patient safety event reviews (PSERs): Roles & responsibilities

Process step	Role	Actions
Step 1: Initiate Engagement readiness and team preparation	Quality & Safety Director (QSD)	• Identify staff members to lead the work.
		• Bring core committee members together to discuss patient and family partner participation in PSERs. • Explain why, when, and how PFPs will be involved. • Discuss level and method of engagement. • Clarify roles of patient and family partners.
	QSD, Patient Experience Director (PXD)	• Confirm staff resources and budget for PFP expenses and honoraria. • Identify support systems for patient partners.
Step 2: Plan Engagement objectives, role clarity, and training	Quality & Safety Manager (QSM), Patient Experience Leader (PX leader)	• Review education plan, identify staff for training ("core" committee members), and deliver session (MODULE 1: Staff foundations)

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

- **Appendix A:** Roles & responsibilities
- **Appendix B:** FAQs
- **Appendix C:** Process for patient & family participation in patient safety event reviews
- **Appendix D:** Patient safety event review: Process overview

References

Patient & family partner (PFP) participation in patient safety event reviews (PSERs): Roles & responsibilities

Process step	Role	Actions
Step 3: Partner Finding and inviting patient and family partners	QSD	• Confirm number of positions available. (Suggested minimum is a pool of five patient partners)
	QSL, PX Leader	• Draft engagement invitation.
		• Invite participation (i.e., share with local patient partner network, post on Patient Voices Network)
	QSD, PXD and/or QSM, PX Leader	• Complete selection process (e.g., meet and greet, interview)
		• Select applicants for PFP pool
	QSM, PX Leader	• Offer opportunity to PFPs for to join pool
Step 4: Connect Welcome and support patient and family partners	QSM, PX Leader, admin support	• Host an introductory meeting. • Go through onboarding and orientation checklist.
	QSD/QSM, PXD, admin support	• Deliver virtual training sessions (MODULE 2: Patient & family partner foundations) • MODULE 3: Joint practical session — mock review
	Patient and family partners	• Submit signed PFP agreement form. • Complete mandatory training (see education plan) • Attend virtual training session (MODULE 2: Patient & family partner foundations)
	"Core" committee members	• Participate in virtual training session with PFPs (MODULE 3: Joint practical session — mock review)

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

Appendix A: Roles & responsibilities

Appendix B: FAQs

Appendix C: Process for patient & family participation in patient safety event reviews

Appendix D: Patient safety event review: Process overview

References

Patient & family partner (PFP) participation in patient safety event reviews (PSERs): Roles & responsibilities

Process step	Role	Actions
Step 5: Involve Facilitate the participation of PFPs in review committee meetings	Identified Quality Lead (director or manager) and review committee chair	• Identify PSER for PFP inclusion (see review selection criteria)
	Quality Manager, PX Leader	• Share review details with PFP pool • Identify 2x PFPs for to join review committee
	RC Chair, Quality Manager, PX Leader	• Engage in readiness conversation with PFPs • Engage in readiness conversation with staff • Complete check in meeting before review (PFP check in checklist)
	Admin support (on behalf of review chair)	• Send review meeting invitations to review committee members with embedded purpose and role of PFPs, FAQs, PSER package
	Patient and Family Partners	• Read upcoming review details; decline, or express interest in supporting review • Recuse as needed if conflict identified • Participate in readiness conversation, check-in meeting with review chair • Prepare for and attend review meetings • Provide a patient and family perspective in analysis • Help develop recommendations • Maintain confidentiality (Section 51)
	PSER committee members	• Prepare for and attend review meetings • Participate in readiness conversation with chair • Participate in safety event analysis • Develop recommendations • Maintain confidentiality (Section 51) • Listen to understand patient and family perspectives

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

Appendix A: Roles & responsibilities

Appendix B: FAQs

Appendix C: Process for patient & family participation in patient safety event reviews

Appendix D: Patient safety event review: Process overview

References

Patient & family partner (PFP) participation in patient safety event reviews (PSERs): Roles & responsibilities

Process step	Role	Actions
Step 6: Conclude Close the loop and evaluate	Review Committee Facilitator, admin support	• Send post PSER survey to committee members • Complete debrief meeting with PFPs, formally acknowledge end of review and express thanks • Share CTL communications with PFPs (i.e., learning summary)
	Patient and Family Partners	• Complete post PSER survey • Suggest ways to improve the process • Communicate concerns to key review contacts

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

- **Appendix A:** Roles & responsibilities
- **Appendix B:** FAQs
- **Appendix C:** Process for patient & family participation in patient safety event reviews
- **Appendix D:** Patient safety event review: Process overview

References

Appendix B

FAQs

Why are patient and family partners included in PSERs?

They bring unique lived experiences to uncover system factors and propose practical, patient-centred solutions.

Can they join a Section 51–protected review?

Yes, Section 51 does not prohibit external participants if they bring relevant expertise.
All participants must abide by Section 51's confidentiality rules.

What is the patient and family partner's role in PSERs?

They attend review meetings, share perspectives, assist in developing recommendations, and maintain confidentiality.

How are they recruited?

Through Patient Experience and Quality & Safety teams, often via local networks or Patient Voices Network.

How are orientation and onboarding handled?

They sign confidentiality agreements, complete orientation/training with QSL or Patient Experience leads and learn about patient safety, just culture, the PSER process and Section 51 requirements.

What about negative past experiences?

Most partners want to prevent others from having similar negative experiences.
If something feels "too close to home," patient and family partners are encouraged to recuse themselves.

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

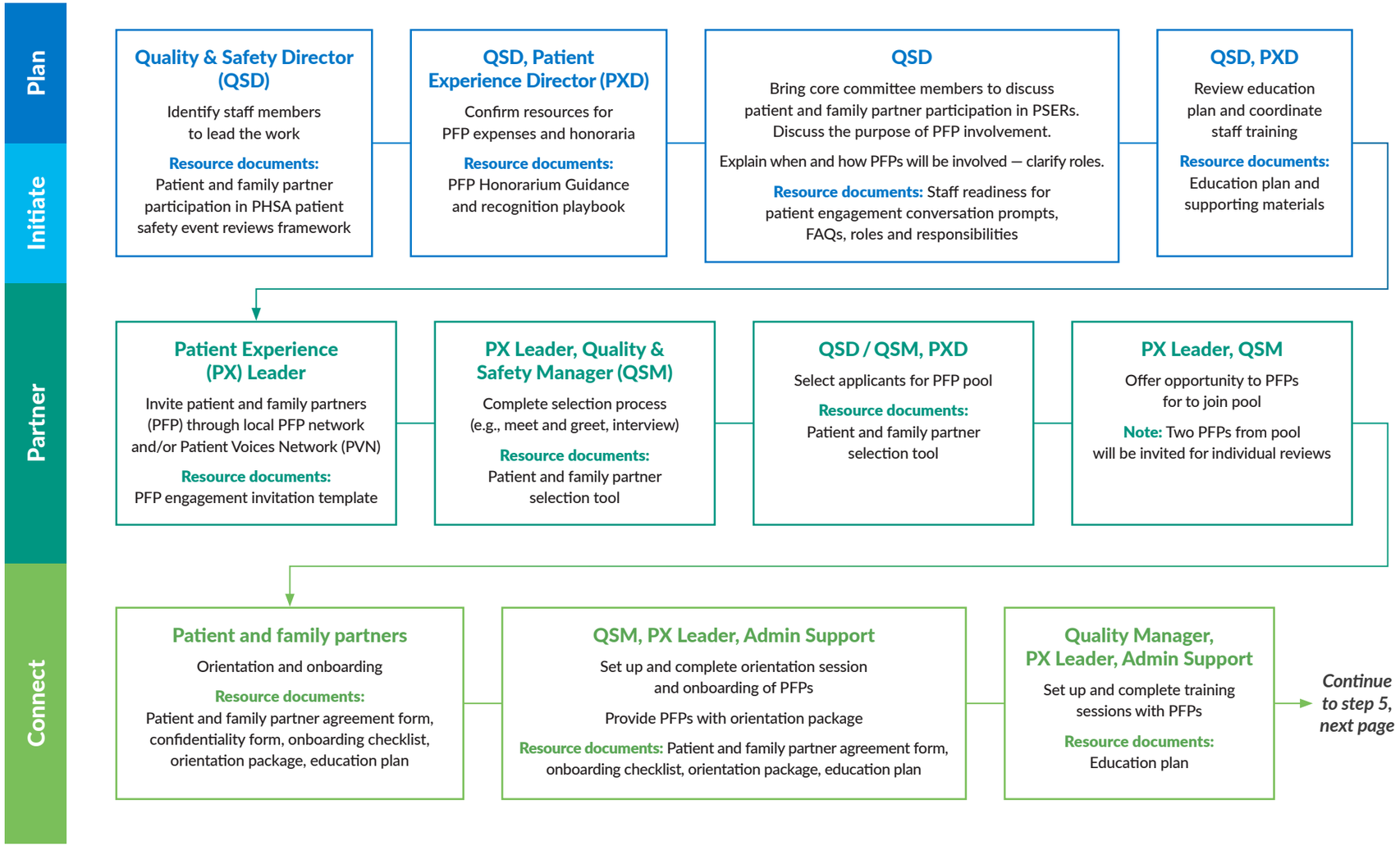
- **Appendix A:** Roles & responsibilities
- **Appendix B:** FAQs
- **Appendix C:** Process for patient & family participation in patient safety event reviews
- **Appendix D:** Patient safety event review: Process overview

References

Appendix C

Process for patient & family participation in patient safety event reviews (PSERs)

The following steps are designed to establish a foundation for partnership working on PSERs.



PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

- **Appendix A:** Roles & responsibilities
- **Appendix B:** FAQs
- **Appendix C:** Process for patient & family participation in patient safety event reviews
- **Appendix D:** Patient safety event review: Process overview

References

Process for patient & family participation in patient safety event reviews (PSERs)

These steps should be completed for each review to ensure a consistent and collaborative approach.

Continued from step 4, previous page

5 Involve

Review committee (RC) chair & QSD or QSM

Identify PSER for PFP inclusion

Resource documents: Criteria for PFP involvement in PSER committee

QSM, PX Leader

Identify 2x PFPs for inclusion

Resource documents: Criteria for PFP involvement in PSER committee

RC Chair, QSM

Engage in readiness conversation with PFPs

Resource documents: Review kick-off checklist

Admin support (on behalf of RC Chair)

Sends invitation to PSER committee members with embedded purpose and role of PFPs, FAQs, PSER package

Resource documents: Roles & responsibilities, FAQs

RC chair, PX Leader

Complete PSER preparation meeting with PFPs to support readiness for review committee meeting

Resource documents: Patient and family partner 1:1 check-ins

RC chair, RC facilitator

Complete PSER check-in with staff to support readiness for inclusion of PFPs in review committee meeting(s)

Resource documents: Patient engagement readiness conversation guide

RC Chair & RC Facilitator

Conduct 1–2 Review meetings with committee members to:

1. Understand the event and timeline
2. Review summary of evidence
3. Identify key individuals for perspective sharing meetings
4. Identify contributing factors and incidental findings using QI tools;
5. Discuss if subgroup is needed to conduct investigations in between RC meetings.
6. Generate recommendations and the estimated timeline.
7. Complete the program PSER report using appropriate template(s)

6 Conclude

Admin support (on behalf of RC Chair)

Send Post PSER Survey to all PSER committee members

Resource documents: Post PSER survey

RC chair, RC facilitator

Complete debrief meeting with patient partners:

- to obtain feedback on recommendations and review process,
- discuss impact of their involvement in the PSER process

Resource documents: Patient and family partner 1:1 check in

RC chair, RC facilitator

Formally recognize the end of the review and offer appreciation for their contributions.

Include partners in any CTL post review communications sent to the committee members, i.e., learning summary.

PHSA Patient Safety Event Reviews

Land acknowledgement

About this framework

Background

PART A: Create an environment for partnership

PART B: Engage and enable committee members

PART C: Implement and sustain change

Definitions

Appendices

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- **Appendix B:** FAQs
- **Appendix C:** Process for patient & family participation in patient safety event reviews
- **Appendix D:** Patient safety event review: Process overview

References

Appendix D

Patient safety event review: Process overview

Immediate response	Prepare analysis	Analysis process	PSER report approval process	Follow through	Close the loop
• Staff ensure immediate safety needs are addressed as possible • Staff follow disclosure policy & procedure • Staff report to manager / supervisor through PSLS • Manager / lead receives, reviews • PSLS handler confirms degree of harm • L1/2 complete concise review • L3 and above see next phase	• Quality team facilitates initial determination meeting with applicable leadership • Use decision tree to decide on review methodology: comprehensive, critical comprehensive, concise, multi-incident	The review committee chair and facilitator conduct two review meetings (additional meetings may be required based on the complexity of the event) with committee members. During meetings members: • Are oriented to the event and timeline; • Review summary of evidence; • Identify key individuals for perspective sharing meetings • Identify contributing factors and incidental findings using quality improvement tools; • Discuss if creating small working groups is needed to conduct investigations in between review committee meetings. • Generate recommendations and the estimated timeline • Complete the program PSER report using appropriate template(s)	• PSER report presented to the program's Q&S committee/council. i. The Q&S committees/ council approve the report if no revisions are required. ii. If revisions are required, the report is revised and shared with the review committee members. iii. If the recommendation owner(s) are not part of the review committee (varies by program), a Quality team designate notifies them as soon as possible regarding revisions. • Complete summary report • Risk lead saves approved report in PSLS	• Review committee chair or facilitator or Quality team designate connects with the recommendation owner(s) to discuss the implementation of approved recommendations. • Quality team designate checks in with owner(s) during implementation process and offers support, as needed • Appropriate board committee review data in the recommendation dashboard to monitor the status of implementation, as needed.	• To promote learning from patient safety events, the Quality director or designate follows the Learning Summary process. • Review committee chair, facilitator or PSLS handler (or designate) ensures there is follow up with the PSLS reporter if they are not involved in the review committee.

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