Health Quality 5.0: Putting Patient Safety Back on the Front Burner: The Time Is Now

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Abstract

The focus on patient safety in Canada has been displaced – not because the safety issues have been solved, but because priorities have shifted. This article explores the risks of reduced vigilance and offers evidence-based strategies to recentre safety. It emphasizes the need to protect healthcare workers and meaningfully involve patients and families. Clear actions are outlined for governments, health systems, healthcare leaders, providers and the public. A coordinated, sustained approach to safety can unlock resources, boost productivity and enhance prosperity. Restoring safety as a core element of high-quality care is essential across all levels of the health system.

Introduction

The focus on patient safety in Canada has been displaced by other challenges – not because we have solved the safety issues, but because safety has been crowded out by other priorities. Following the coronavirus disease (COVID-19) pandemic, patient safety was displaced by recovery efforts, workforce burnout, climate change and heightened political and economic uncertainty. Globally, we see national-level commitment and action to improve and sustain patient safety, but in Canada, this emphasis has diminished.

We must put safety back on the front burner.

Patient safety is "the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum" (WHO 2023). Every person in Canada deserves safe, high-quality healthcare when and where they need it. But today, patients are harmed by the services intended to help them.

This article examines the consequences of deprioritizing patient safety and the benefits of amplifying its importance. As long-standing champions of patient safety, we aim to put the spotlight on patient safety once again, inspiring action and meaningful change – fit with today's context. We know this is not easy. But ignoring or diminishing safety is simply not an option for healthcare leaders. To support our call to action, we present evidence-based strategies to safer practices, cultures and infrastructure, ensuring patient safety remains a priority amid emerging threats. Our notion of safety is comprehensive – it encompasses physical, psychological and cultural safety for the workforce, and is only achievable through meaningful engagement of patients and families in all aspects of the health system.

This is the fifth article in a six-part series called *It Is Time for Health Quality 5.0 – Are You Ready?* The series explores the top challenges facing leaders, intending to create an integrated, people-centred health system supported by learning and evidence-based improvement. This series is designed to stimulate reflection, dialogue and most of all – action. The future of safety in an era of personalization demands fresh perspectives. We look forward to hearing what you think of our proposed directions!

Where We Started and Where We Are Now

While patient safety has a long history, it is only relatively recently that we recognized much harm was preventable and the focus needed to shift from individual errors to poorly designed systems (Leape 1994). This shift was magnified in the publication *To Err is Human* in 2000, which estimated that 44,000–98,000 patients die from preventable errors in American hospitals annually (Institute of Medicine 2000). Subsequently, substantial efforts were made to identify sources of error, develop safety metrics and create effective policies to improve safety (Lark et al. 2018).

The report *Crossing the Quality Chasm* closely followed; it defined quality in six dimensions: safety, effectiveness, patient centredness, timeliness, efficiency and equity (Institute of Medicine 2001). Globally, there is agreement on the importance of these six dimensions of quality. What is less recognized is their interconnection; without safety, equity, efficiency and access will not be achieved.

Between the 1990s and early 2000s, the US, Australia and England all conducted studies on hospital safety. Yet in Canada, the safety focus was minimal until the 2004 Canadian Adverse Events Study revealed that 7.5% of patients in acute care hospitals experienced adverse events (Baker et al. 2004).

> It's always been the case that commitment to patient safety is widely expressed. But follow through on that commitment to doing all of the things necessary to fully embed it in health systems...in everyday practice for every healthcare professional [falls] well short from the front burner. The challenge all along [has been] to put patient safety within the mainstream of clinical practice, health service management and design. Sir Liam Donaldson, WHO Director-General Special Envoy for Patient Safety, Former Chief Medical Officer, NHS England. (L. Donaldson, personal communication, April 4, 2025)

Policy influence

"Politicians set the societal rules that have a profound impact on who will be well" (Philpott 2024). In 2003, the Government of Canada took a significant step in funding the Canadian Patient Safety Institute (CPSI) to provide national leadership and coordination in patient safety improvement. Concurrently, the Government of Canada funded the development of the Canadian Medication Incident Reporting and Prevention System (CMIRPS) (Hassen et al. 2006).

Since this time, many health professional bodies, associations and provincial and territorial organizations have collaborated on national programs or introduced new programs to improve patient safety. However, we have fallen short in demonstrating results. Efforts are fragmented, and for the most part, voluntary. When Accreditation Canada, our largest independent accreditation organization, first introduced required organizational practices focused on reducing preventable harm, there was enthusiasm and investment. However, over time, there have been challenges in implementing and sustaining these programs and practices at scale. Today, we have the Health Standards Organization (HSO) and other Standards Development Organizations (SDOs) producing National Standards of Canada. Nevertheless, the lack of policy levers in place leads to inconsistent adoption across the health system.

The WHO *Global Patient Safety Action Plan* (GPSAP) points to the critical role that governments and policy levers play in eliminating preventable harm (WHO 2021). The GPSAP calls for every country to resource a comprehensive patient safety strategy and national plan that leverages standards, legislation, monitoring and public reporting to protect patients and healthcare workers from harm (WHO 2021). Today, Canada is one of the only countries in the world without a national patient safety plan. There is no unified approach or resolve that keeps the spotlight on safety. We believe progress is possible, notwithstanding the federated healthcare model challenges and our fragmented approach to safety across many well-meaning organizations. Patient safety is a choice, and it is time to choose access to safe, high-quality care as a fundamental right for all Canadians.

Markers of progress

Our experience with patient safety over the past quarter century has had numerous stops and starts, much like a game of snakes and ladders. We make advances, but too often we slide back due to shifting priorities, insufficient funding and resource capacity. Fiscal constraints and political cycles make it difficult to sustain patient safety work.

During the COVID-19 pandemic, the workforce was understandably focused on the immediate safety needs of patients, including a relentless focus on infection control. Limited family presence also impacted patient safety (HEC 2023). Human resource challenges led to prioritizing staffing. Frequently, this involved the recruitment of less experienced staff and reliance on temporary staff, often with condensed orientation and onboarding. These trends made safe and reliable practices difficult to sustain and negatively influenced patient safety (WHO 2022).

Economics of unsafe care

While safety is an important quality strategy, it also provides economic benefits. In Canada, hospitalization costs for patients who experience harm are 4.5 times higher ($42,558) compared with those without harm ($9,072) (CIHI 2024a). The Organisation for Economic Co-operation and Development (OECD) reports that 13% of healthcare

spending focuses on the direct costs of unsafe care (Slawomirski and Klazinga 2022). Canada's healthcare spending in 2024 was estimated at $372 billion and outpaced economic growth (CIHI 2024b). This means that Canada may be spending $48 billion annually on the direct costs of unsafe care (CIHI 2024c; Slawomirski and Klazinga 2022). Furthermore, patient harm significantly reduces productivity and increases income loss, imposing indirect costs on economies (WHO 2024a).

These findings highlight the significant economic advantages of addressing patient safety. By tackling the safety issues in a sustained and coordinated way, we unlock valuable resources, improve productivity and increase prosperity for all Canadians.

The path forward can be illuminated by learnings from successful initiatives – where leadership, resources and collaboration advanced patient safety. One example of this is in surgical safety.

The National Surgical Quality Improvement Program (NSQIP) is a cost-effective way to advance patient safety. Initially implemented in the US, NSQIP was launched in Canada in 2015 (Jackson et al. 2018). This program reduces surgical complications, enhances patient outcomes and enables the adoption of evidence-based practices across participating hospitals. Improvements are attributed to clinician leadership and rigorous adherence to safety practices, reinforced by meaningful data for monitoring local improvement and producing and providing comparable data for collaborative learning. Participation in a community of practice among hospitals has contributed to faster improvement and increased quality-improvement capacity (Jackson et al. 2018).

Thirteen hospitals spanning British Columbia, Alberta and Ontario were recognized for meritorious outcomes in the latest American College of Surgeons report (ACS 2024). Evaluations in Alberta found that net cost-savings were $8.8 million from 2015 to 2017 (Thanh et al. 2019). Similarly, the Ontario evaluation found over $3 million in savings annually, a 38% return on investment (Ontario Health 2023). Despite the considerable impact of these programs, they have not been scaled for maximum impact. Meanwhile, CIHI hospital harm data shows nearly 11,000 post-procedural infections in 2023–2024, and the overall hospital harm rate has increased by 13% between 2014 and 2024 (CIHI 2024d).

CIHI and Healthcare Excellence Canada (HEC) partnered on reducing hospital harm, publishing the hospital harm improvement resource and national-level hospital harm data (CIHI 2024d; HEC 2025). While hospital-level data is refreshed monthly, it is only available to designated users (CIHI, health system performance team, personal communication, April 22, 2025). Increasing data transparency on the extent of unintentional harm and the costs of unsafe care across Canada would stimulate improvements.

We know what to do – why is it so hard?

We know what needs to be improved, but we are struggling to make lasting changes in patient safety. The reality is that our understanding of safety has expanded, and this can make the journey even more challenging. We need to take into account physical, psychological and cultural safety as well as consider the impact of environmental sustainability and emerging technologies. None of this can happen without meaningful engagement, acknowledging patient and system complexity, as well as workforce health. There are many human factors at play when designing and sustaining solutions. So, how do we move forward to implement proven practices without overwhelming staff?

Patient, family and caregiver involvement to improve safety

Patients and their families are central to the achievement of a safer health system. Engaging patients in care, when done well, improves safety and can reduce the burden of harm by up to 15% (Tan 2022; WHO 2023). Yet, dismissing patient and family concerns was number one on the *2025 Top 10 Patient Safety Concerns* report (ECRI and ISMP 2025). Questioning a patient's concern without proper medical evaluation can lead to misdiagnosis, delayed treatment, prolonged suffering and distress. One study found that 55% of respondents reported worsened symptoms after a doctor dismissed concerns, and 28% said they experienced a health emergency due to a provider's lack of response (ECRI and ISMP 2025).

The WHO *Patient Safety Rights Charter* makes the bold and explicit link between patient safety and human rights. Member states, including Canada, are called upon to adopt, disseminate and implement the ten rights that are crucial for "mitigation of potential risks and prevention of patient harm" (WHO 2024b). This rights and risk-based approach to improving outcomes is a step forward, and we look forward to Canada's explicit commitment to the charter, bringing patient safety back to the forefront.

Countries with national safety plans in place are deliberate in their commitment to ensure that the voices of patients and families are being heard. In Scotland, for example, patients and families are actively involved in the national safety plan to reduce infections and improve transparency and accountability for safety. Jason Leitch, who was responsible for quality and safety strategy for the Scottish Government, told us about the power of providing an online platform to provide feedback on care. "The most important thing we've done in the last 10 years is Care Opinion. The result is amazing stories, mostly good and some challenging – it's been transformational" (J. Leitch, personal communication, March 5, 2025). The National Health Service (NHS) Scotland annual review highlights patient, family and public input. Staff and leaders promote the platform and use feedback to reflect, celebrate success and improve (NHS Scotland 2024). Scotland also

recently appointed a new patient safety commissioner, a role modelled after the world's first patient safety commissioner for England, created in 2022. These commissioners have independent authority and accountability at the highest levels of government, which is a bold public statement, reinforcing the importance of patient safety.

Patient and system complexity

Changes in disease incidence have also increased safety risks. Multi-morbidity, polypharmacy and treatment complexity can lead to unforeseen complications. For instance, an oncologist may effectively treat a patient with cancer but lack expertise in managing their chronic conditions. Conversely, a family doctor may excel in managing chronic conditions but be unfamiliar with cancer care. Effective communication and transitions between care providers are vital. This requires leadership, integrated team-based care, structured communication, interoperable systems and appropriate use of technology.

Beyond the number of diseases or medications, patient complexity is influenced by health literacy and socio-economic, cultural, environmental or behavioural factors. A patient with a single condition can be complex if there is a language or financial barrier, while a patient with multiple, well-controlled chronic conditions may be easier to support (Nicolaus et al. 2022). CIHI found that communication barriers leave some patients more vulnerable to harm. Hospital harm is 30% more likely in non-English or non-French speaking patients (CIHI 2024a).

Historically, Safety-I approaches have been the dominant paradigm, focused on identifying and preventing harm and improving practices. There is a need to move to approaches that reflect the non-linear complexity of healthcare (Deutsch et al. 2022). According to James Frederick, a safety expert, "We must change the narrative on prevention – to prevention and control, acknowledging that safety hazards are a moving target" (Stephenson 2023). We need to balance the Safety-I mindset, with a Safety-II mindset. Safety-II takes a broader, proactive approach, identifying and spreading positive practices. Frederick says, "Safety-II recognizes workplace complexity and places the greatest value on the expertise of the frontline. It prizes situational awareness, flexibility and a state of readiness to adapt and achieve the best possible outcome for the conditions at hand" (Stephenson 2023).

Two examples of Safety-II thinking are *Breaking the Rules for Better Care* and frontline ownership. *Breaking the Rules for Better Care* focuses on removing barriers, improving patient and workforce engagement and innovating improvements (IHI 2025). Frontline ownership is about engaging teams in adapting and implementing standards that reflect the local context and result in sustained improvement (Gardam et al. 2017).

Dr. Leitch reinforces these approaches, suggesting a focus on safety strategies that highlight visible changes that frontline providers can see and influence. "The patient pathway from acute or chronic disease entry to the system needs to be optimized. We need to think about safety in the sense that not admitting the patient may be the safest thing to do. Getting out quickly is also the safest thing to do." (J. Leitch, personal communication, March 5, 2025).

Strengthening the relationship between workforce safety and patient safety

Achieving patient safety requires a healthy, sustainable workforce. "Investment in a healthy workforce enhances health system resilience, lowers the cost of occupational harm and contributes to minimizing patient harm" (de Bienassis et al. 2021). A positive patient and workforce safety culture improves patient outcomes, including lower rates of surgical site infections, falls and medication errors. Patients also report better care experiences when the patient safety culture is strong. When psychological safety is high, event reporting rates and teamwork improve (Murray et al. 2024).

HSO's recent Global Workforce Survey (GWS) analysis found that 80% of respondents experiencing low burnout are satisfied with their jobs, have a psychologically healthy and safe work area and rate their unit's patient safety grade as "very good" or "excellent" compared with the 24%–42% of respondents who frequently experience burnout (Lowe 2024). Improving patient outcomes will be limited without attending to a healthy workforce and safety culture.

Recognizing that the health system is complex and dynamic, some organizations are applying high-reliability principles to instill safety and learning cultures. The high-reliability mindset includes a preoccupation with failure, a heightened sensitivity to monitoring operational activities, a reluctance to simplify in the face of complexity, an enduring cultivation of and deference to expertise and a deep commitment to organizational resilience (Macrae 2025). These principles are associated with improved safety outcomes for patients and the workforce (Vogus et al. 2025).

Another path to improving safety is through reducing complexity and low-value activities. Removing low-value activities, such as redundant charting, creates space for interventions with impact. The psychology and economics of safety are two sides of a very positive story and make it easier for staff to do the right thing.

Aligning levers to action

Canada's infrastructure investment must incorporate safer designs that ensure safe, reliable care is achieved and sustained across the healthcare continuum. "Improving patient safety requires a whole of system approach. Value is created by

implementing and investing in mutually re-enforcing interventions within a policy framework that encompasses the entire health system" (Slawomirski and Klazinga 2022). Evidence shows the most cost-effective strategies to address fragmentation are multi-modal and align clinical, organizational and system-level strategies (Slawomirski and Klazinga 2022). System-level solutions require integrating safer care into practice and across the care continuum. This can be supported by appropriate use of technology, accountability and a safety culture.

Transparency and accountability

The extent of unsafe care is unknown to patients and the workforce. To advance a safety culture, transparency must be valued, not weaponized. The politics around transparency and accountability impede public and provider awareness and collective action. Sustaining patient safety in Canada requires regular organization-level reporting. Comprehensive "never event" incident reporting is not fully implemented, making it easy to obscure issues. Greater transparency and comparable data reporting would show that safety issues have not been resolved. Canada has the data repositories and the capabilities to drive patient safety improvements.

New Accreditation Canada *Revised Safety Practices* (RSPs) are well-aligned with the safety gaps discussed. These include *Partnering with Clients to Improve Safety, Safe Care Transitions, Health Equity and Surveillance for Hospital Acquired Infections* (Accreditation Canada 2025).

Harm is also reduced by adhering to professional standards and accreditation standards and practices. These are evidence-based and focused on "what" needs to be demonstrated. "How" standards are applied must be based on population needs, care setting and resources. Regulated providers must follow professional standards. Examples include optimizing safe care transitions, using structured communication and working effectively with interdisciplinary teams (BCCNM 2025; CNO 2025; Frank 2015).

The WHO *Global Patient Safety Action Plan 2021–2030* offers ways to measure progress and learn from other universal healthcare systems. "Policy interventions such as regulation, accreditation, leadership, safety culture, competency building and public reporting can be driving forces for patient safety improvement. These inventions show value by significant reductions in harm at the point of care. They should be complemented with downstream patient safety improvement interventions that include capacity building, reporting and learning systems, teamwork and communication, patient (and family) engagement and improved clinical care processes" (WHO 2021).

While there is no shortage of guidance out there, what is missing is a practical implementation strategy that includes monitoring and reporting of prioritized safety practices. The recent International Society for Quality in Healthcare white paper, *Safe Care is the Right Care*, focuses on the critical patient safety dimensions of advocacy, leadership and equity, health workforce education and safety, patient and family engagement and empowerment and improvement in clinical processes (ISQUA 2025). These reports do not convey new knowledge but offer necessary steps on the "what" and "how" to enable collective commitment to action.

So, where do we go from here? After consideration of the current and potential future state for safety, we propose six calls to action outlined in Table 1. Calls to action are just the beginning, however, as outcomes will only improve when all players are actively working together to eliminate preventable harm, for good.

TABLE 1.
Six calls to action to advance patient safety in Canada

System collaborator/ stakeholder	Action required
Federal, provincial and territorial governments	Leverage existing national standards and performance data to establish national patient safety strategic priorities and action plans across the health system. Align requirements and incentives with sustained funding, infrastructure, enabling policies and biannual progress monitoring. Convene a national FPT (federal / provincial / territorial) safety summit with key stakeholders and consider the appointment of a patient safety commissioner for Canada.
Health systems and healthcare leaders	Embed patient safety infrastructure, policies and strategies at the regional, sector and organizational level. Ensure that the capacity to implement and evaluate progress on national patient safety priorities is enabled by a culture that advances transparency, learning and improvement.
Providers (regulated and unregulated)	Collaborate with regulatory colleges and associations to implement policies, strategies and action plans locally based on population needs. Sustain a safety culture through capacity development, technology and evidence-based practice.
Patients, families and the public	Actively engage in the co-design of all aspects of the health system to promote patient safety and improved health literacy. Demand transparency of patient safety data and actions for improvement, including the adoption of the WHO patient rights declaration.
Academia and research	Grow the necessary human and knowledge resources and innovation to improve safe, reliable and sustainable healthcare based on evolving evidence and global learning.
Associations and organizations	Adopt evidence-based standards, comparable data and resources that promote learning, spread and scale of successful initiatives.

Conclusion and the Path Ahead

Access to safe, high-quality care should be a fundamental right for all Canadians. Not only does safer care save and improve lives, but it is also critical for a prosperous and productive society where everyone can thrive. History illustrates that making this happen cannot be left to chance. Our five calls to action require a deliberate, well-resourced agenda for change supported by accountability systems that span federal, provincial and territorial boundaries. While we may not be able to break down every barrier – with courageous leadership at every level, silos and systems can be connected for impact.

As long-standing champions and leaders of safety in Canada and beyond, we see both the opportunities and challenges that can be harnessed for change. There are many individual and isolated examples of excellence, but it is time to come together and make meaningful gains toward the goal of patient and workforce safety for everyone. Collectively, we possess the essential elements for improving safety … and now we must build on these with the intention to increase impact. Each of us has a role to play in both stepping up for safety and letting go of long-standing practices and approaches that get in the way.

The next and final article in this series will focus on the leadership imperative for rebuilding trust and confidence in our healthcare system. New models of partnership and collaboration are vital. Patient safety is a team sport, and the game is changing – requiring a new playbook. Let us write it together. There is no time for delay in putting patient safety back on the front burner. HQ

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