# Fraser Health Together:

## Quality Improvement Charter

**Title of Quality Improvement Initiative:** Building a Just Culture Across Fraser Health

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**Quality Improvement Initiative Start Date:** March 2021

**Last Revised:** August 2026

## What are we trying to improve?

**Problem:** Fraser Health, as a multi-institutional Healthcare organization, experiences barriers to incident reporting and organizational learning due to fear of blame, inconsistent accountability practices, and varying levels of psychological safety among healthcare workers.

**Rationale:** Implementing and strengthening a Just Culture promotes open communication, fair accountability, and continuous learning from errors and near misses, leading to improved patient safety, enhanced staff engagement, and better quality of care.

**Initiative Description:**

*Define target population and area..*

The "Just Culture in Action" quality improvement and patient safety initiative aims to increase awareness, understanding, and application of the Just Culture principles across Fraser Health. Using quality improvement methodology, through a PDSA cycle, a Just culture video was developed and premiered during Patient Safety Week. Through feedback, the video transpired into an interactive training module to enable staff access to education on demand, including Patient Safety Essentials Series and Pulse Page.

This initiative also incorporates Just Culture principles into existing patient safety and quality improvement education programs, including **QI Essentials training**, which is accessible to all Fraser Health staff regardless of their role, program, or service area. Additionally, the **2024 Surgical Summit** highlighted the application of Just Culture within the surgical setting, reinforcing the importance of fostering a learning environment that supports patient safety, accountability, and continuous improvement.

By embedding Just Culture principles into organizational learning and daily practice, the initiative supports leaders, physicians, and staff in fostering a psychologically safe environment where concerns can be raised openly, learning is encouraged following patient safety events, accountability is balanced with fairness, and continuous improvement is promoted. Ultimately, the initiative strengthens event reporting, organizational learning, and the systems that support safe patient care.

**Scope & Boundaries**

***In Scope:*** all Fraser Health (FHA) Staff

**Aim Statement:**

By April 1, 2027, improve the organization's Just Culture by increasing psychological safety, trust in fair accountability processes, and reporting of safety concerns, with a 10% increase in non-anonymous PSLS reporting and a 15% improvement in staff survey measures related to speaking up, fairness, and learning from error.

| How will you know a change is an improvement? | |
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| | **Description** |
| **Outcome Measure** | Number/Percentage of Patient Safety Events (PSEs) reported<br>Staff survey results on perception of psychological safety and just culture<br>Number of days from PSLS Critical Incident (CI) Reported to Quality Review (QR) Occurring<br>Number of days from PSLS CI Reported to Recommendation Completion |
| **Process Measures *(See Appendix A)*** | Number of Just Culture education sessions delivered<br>Number of Staff who have received Just Culture education<br>Number of learning platforms through which Just Culture is available<br>Percentage of PSEs receiving follow-up within target timeframe(s) |
| **Balancing Measures** | Number of anonymous PSLS reports<br>Number of survey respondents<br>Number of overdue PSLS events at all severities |

| | **Description** | **Today** |
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| **Outcome Measure** | 1. # of patient safety events (PSEs) reported<br>2. Staff survey results on perception of psychological safety and just culture<br>3. Number of days from PSLS Critical Incident (CI) Reported to Quality Review (QR) Occurring<br>4. Number of days from PSLS CI Reported to Recommendation Completion | • Patient safety event reporting is expected to increase as psychological safety improves and staff feel more comfortable identifying and reporting errors, near misses, and safety concerns within a supportive environment that promotes learning, transparency, continuous improvement, and fair accountability rather than blame or punishment.<br>• One possible PDSA – Survey on Just Culture pre-QIE and follow-up survey to all QIE attendees. |
| **Process Measures** | 1. Number of Just Culture education sessions delivered<br>2. Number of Staff who have received Just Culture education<br>3. Number of learning platforms through which Just Culture is available<br>4. Percentage of PSEs receiving follow-up within target timeframe(s) | • Over 15 sessions on Just Culture have been delivered through various modalities.<br>• Over 1000 FH Staff have received Just Culture education to date.<br>• QI Essentials Training, Patient Safety Education Series, Surgical Summit ’24, Pulse Page. |

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| **Balancing Measures** | 1. # of anonymous PSEs reported<br>2. # of survey respondents<br>3. Number of overdue PSLS events at all severities | • A high number of anonymous PSLS reported events indicates a culture of blame.<br>• A high # of survey respondents may indicate a positive culture.<br>• A high number of overdue PSLS events (at all severities) may indicate a backlog in patient safety event management as a result of unclear accountability, competing priorities, limited capacity, inconsistent follow-up processes, and lack of visibility or escalation of overdue events. |

| **What changes can we make that will result in an improvement?** | | |
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| **Primary Driver** | **Secondary Drivers** | **Change Ideas** |
| Accessible Just Culture Education | 1. Education available through multiple learning platforms<br>2. On-demand access to Just Culture resources | 1. Integration into QI Essentials<br>2. Patient Safety Education Series<br>3. Canadian Patient Safety Week<br>4. Surgical Summit<br>5. Pulse Page<br>6. Just Culture video recorded sessions |
| Leadership Commitment & Role Modelling | 1. Visible leadership support<br>2. Leaders applying Just Culture principles | 1. EMD/ED Sponsorship<br>2. Encourage staff to report patient harm & near misses |
| Psychological Safety & Reporting Culture | 1. Staff confidence to speak up<br>2. Consistent response to errors and near misses<br>3. Learning-focused patient safety event reviews | 1. Promote non-punitive reporting, “see something say something”<br>2. Embed Just Culture into Quality Reviews |
| Integration Into Daily Practice | 1. Embedding Just Culture into QI and safety work<br>2. Integration into clinical education<br>3. Application during patient safety reviews/discussions | 1. Integration into QI Essentials Training<br>2. Surgical Summit presentation<br>3. Safety huddles, Quality Reviews, M&M Rounds |
| Continuous Learning & Accountability | 1. Feedback and evaluation<br>2. Sharing successes & lessons | 1. Staff surveys<br>2. KYIs, The Beat articles, conference(s) |

| How will we work together to achieve & sustain success? | | |
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| **Key Stakeholders.** Whose input & support will this project require? How will we engage those stakeholders? | EMD & ED, Quality & Safety, Operational Leaders, Physicians, Clinical Staff. | |
| **Team & Key Stakeholders Roles & Responsibilities** | **Name** | **Role & Responsibility** |
| | EMD & ED, Quality & Safety | Outline initiative direction, champion Just Culture principles, obtain organizational support, deliver content. |
| | Operational Leaders | Lead implementation/integration of Just Culture principles with local sites/units/programs. Support staff participation in education, reinforce principles, facilitate discussions following patient safety events, and sustain Just Culture. |
| | Physicians | Champion Just Culture Principles in clinical settings. Promote reporting, learning from adverse patient safety events and near misses, participate in education and discussions, provide clinical expertise, and reinforce Just Culture principles. |
| | Clinical Staff | Apply Just Culture principles into daily practice, participate in education/training, report safety concerns and events, and engage in discussions. |
| **Milestone & Target Dates** | Just Culture Presentation – Surgical Summit: March 11, 2024<br>Just Culture Premier – Canadian Patient Safety Week: Nov 1, 2024<br>Just Culture – Patient Safety Education Series: May 8, 2025<br>Just Culture in Action – Quality & Safety Conference: July 2025<br>December 2025 – Just Culture Education Delivered to 1,000 Fraser Health Staff | |

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| **Barriers.**<br>What barriers do you predict to your success? How will you overcome these barriers? | **Competing Priorities and Capacity Constraints:** staff engagement and attendance due to overall capacity and operational demands.<br>**Strategy:** Offer flexible, on-demand learning options, integrate into existing platforms, use KYI's, the Beat article, and advertise to Physician Groups.<br><br>**Fear of Blame:** Historical experiences, including blaming and shaming, may create reluctance to report adverse patient safety events or near misses.<br><br>**Strategy:** Promote Leadership role modelling and consistent application of Just Culture principles in clinical environments and during patient safety reviews. |
| **Initiative guidelines.**<br>List any guidelines for the team, including project constraints, rules or procedures, technology considerations, etc. | **Education Accessibility:** Project constraint includes limitations and buy-in when developing accessibility to Just Culture education on demand. Education to be available through multiple platforms, including instructor-led, virtual, and on-demand, to maximize accessibility across Fraser Health<br><br>**Integration into Existing Processes:** Just Culture principles to be embedded into existing platforms/processes, including patient safety reviews, QI Essentials, safety huddles, etc. where appropriate. |

| **Sponsor Signature(s)** | |
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| Manager: | Date: |