CHCA Project ECHO

Personal Support Workers

All Teach, All Learn

Building Skills, Knowledge, and Confidence

Canadian Home Care Association

Project ECHO



What Shapes Safer Care at Home?

How PSWs Support Safety, Choice and Risk in Care

Presenter:

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Case Study Presenters:

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Britt LaBrie, Manager, Quality & Patient Experience, CarePartners

Host: Jennifer Campagnolo, Project ECHO Home and Community Care Lead

October 28, 2026

Land Acknowledgement



Artist Credit: Patrick Hunter

As we gather virtually from across Canada, the Canadian Home Care Association acknowledge the many Indigenous territories and homelands from which we join. We honour the First Nations, Inuit and Métis peoples whose relationships with these lands and waters continue today. We recognize their distinct histories, cultures and rights, and invite you to take a moment to reflect on the land you are joining from and the Indigenous peoples connected to it.

Introductions



Carol Fancott
Director, Patient Safety,
Equity, & Engagement
Healthcare Excellence Canada



LuAnn Lederman
Manager Training & Dementia Specialist
Learning & Development Department
CarePartners



Britt LaBrie
Manager, Quality & Patient Experience
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Healthcare Excellence Canada

What shapes safer care?

Canadian Patient Safety Week 2026

Oct. 26-30




HELLO
my name is



OUR PURPOSE

To shape a future where everyone in Canada has safe and high-quality healthcare.

Healthcare Excellence Canada

To shape a future where everyone in Canada has safe and high-quality healthcare.

OUR FOCUS AREAS

To transform **safety, quality and value** across the health sector by integrating:

- Patient, caregiver and community perspectives
- People in the workforce perspectives
- First Nations, Inuit and Métis priorities
- Cultural safety and equity
- Appropriate use of technology



To expand access to **safe, connected, high-quality care** closer to home and community for:

People with primary health care needs

Older adults with health and social needs

OUR PATHS TO IMPACT

We convene and connect people across the country to:

- Spread and scale quality and safety improvements
- Strengthen capacity and collective leadership
- Catalyze policy and practice change

The Waterfall Chat:

What shapes safer care for those you provide care for?

- What do you think makes your clients feel safe?



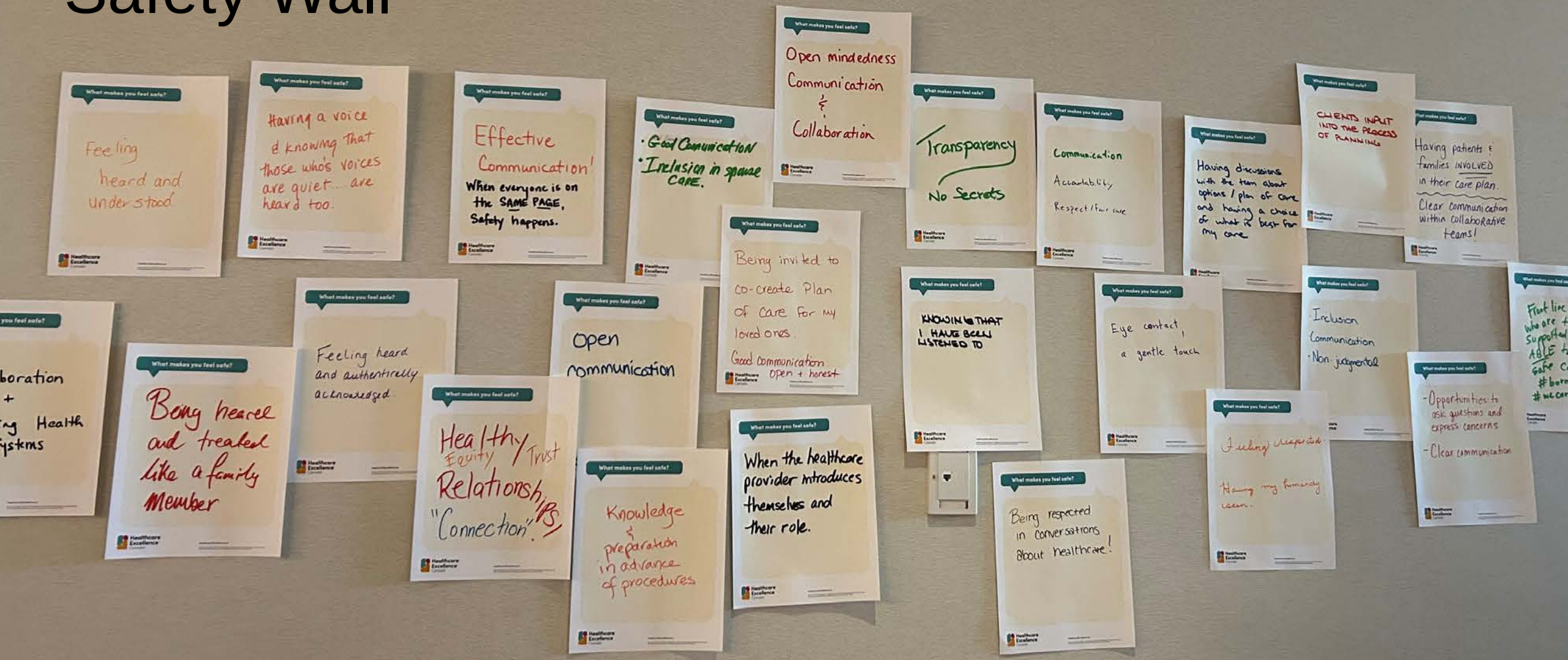
The Waterfall Chat:

What shapes safer care for you to provide care?

- What makes you feel safe in the work you do?



Safety Wall


What makes you feel safe?
Feeling heard and understood
Having a voice & knowing that those who's voices are quiet... are heard too.
Effective Communication!
When everyone is on the SAME PAGE, Safety happens.
· Good Communication
· Inclusion in spaces CARE.
Open mindedness
Communication
&
Collaboration
Transparency
No Secrets
Communication
Accountability
Respect / Fair care
Having discussions with the team about options / plan of care and having a choice of what is best for my care
CLIENTS INPUT INTO THE PROCESS OF PLANNING
Having patients & families INVOLVED in their care plan.
Clear communication within collaborative teams!
Being invited to co-create Plan of Care for my loved ones
Good communication
Open + honest
KNOWING THAT I HAVE BEEN LISTENED TO
Eye contact, a gentle touch
Inclusion
Communication
· Non judgmental
Feeling heard and authentically acknowledged
Open communication
Being heard and treated like a family Member
Health Equity Trust
Relationships
"Connection"
Knowledge & preparation in advance of procedures
When the healthcare provider introduces themselves and their role.
Being respected in conversations about healthcare!
-Opportunities to ask questions and express concerns
-Clear communication

So what we know about safety….

Healthcare Excellence

2004 Canadian Adverse Events Study


The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada

Chart review of

3745 patient charts

in 20 hospitals in 5 provinces using validated review methods

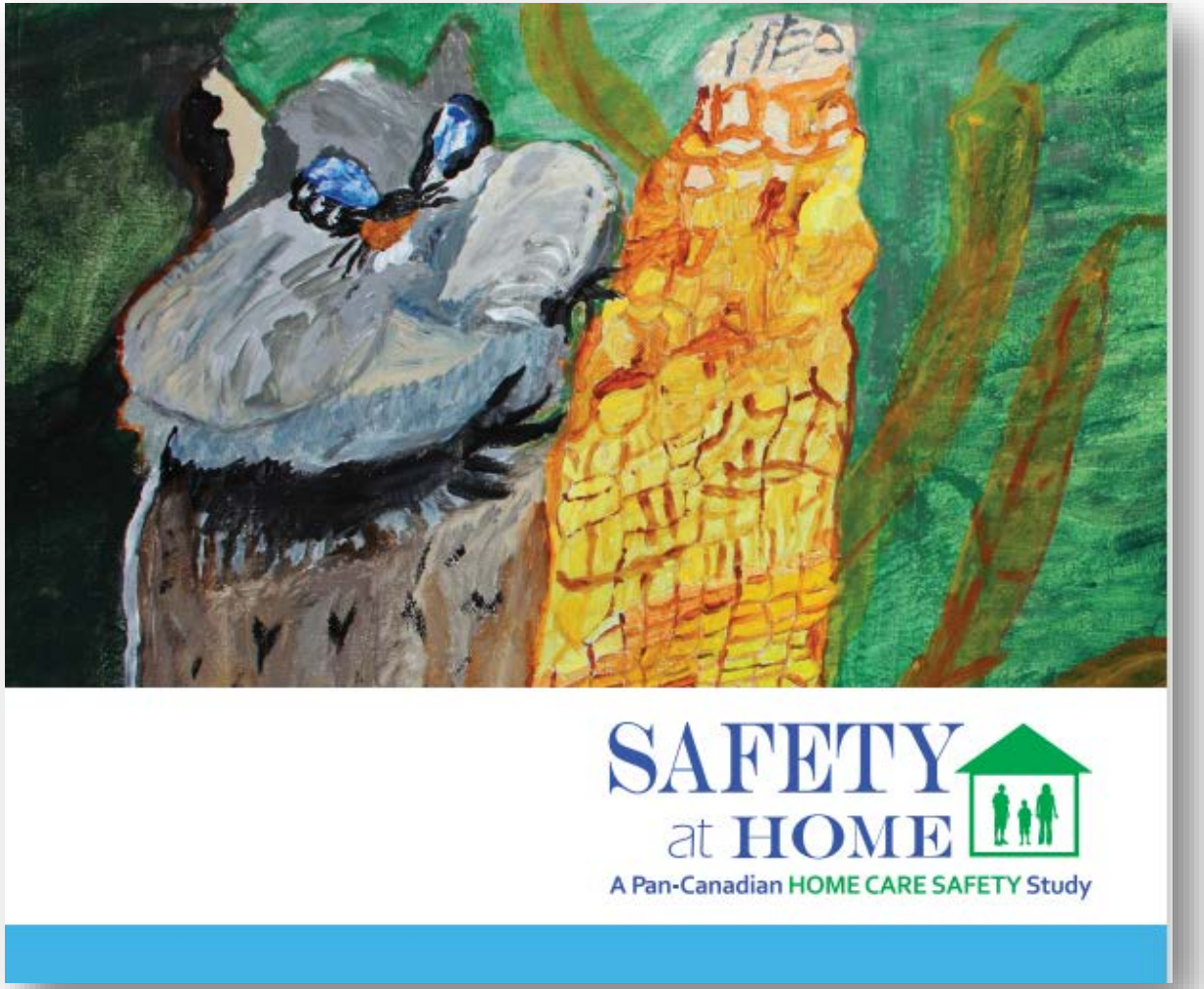
Overall AE rate of 7.5%, of which **37% judged preventable**

Translates to 185,000 events per year and

9250 to 23750 deaths

associated with AEs

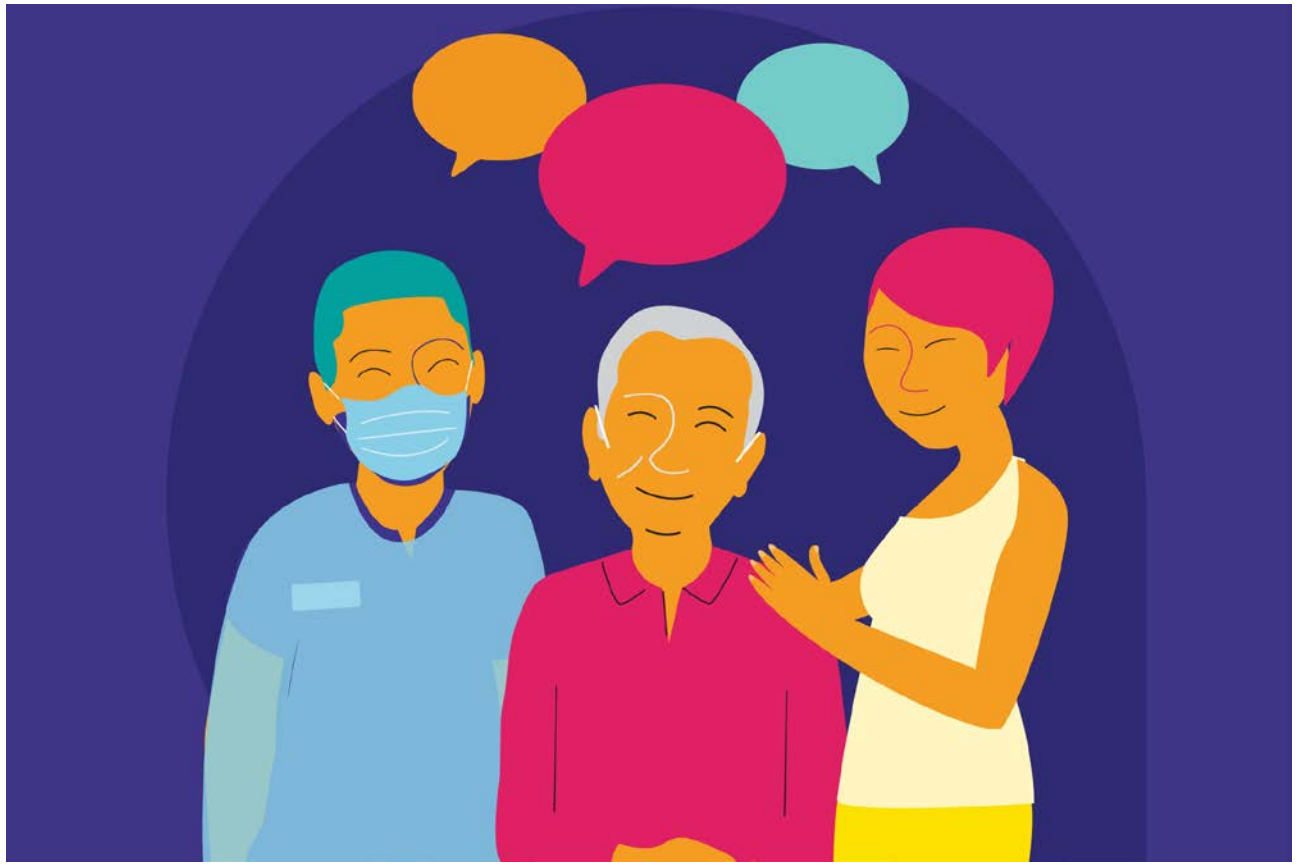
HealthcareExcellence.ca | ExcellenceSante.ca



Blais, Sears, Doran, Baker, et al., 2013

- 2008/2009 Review of Canadian home care charts indicates that **13% of home care clients experienced unintended harm**
- Delirium, sepsis and medication-related harms are associated with an **increased risk of client death**

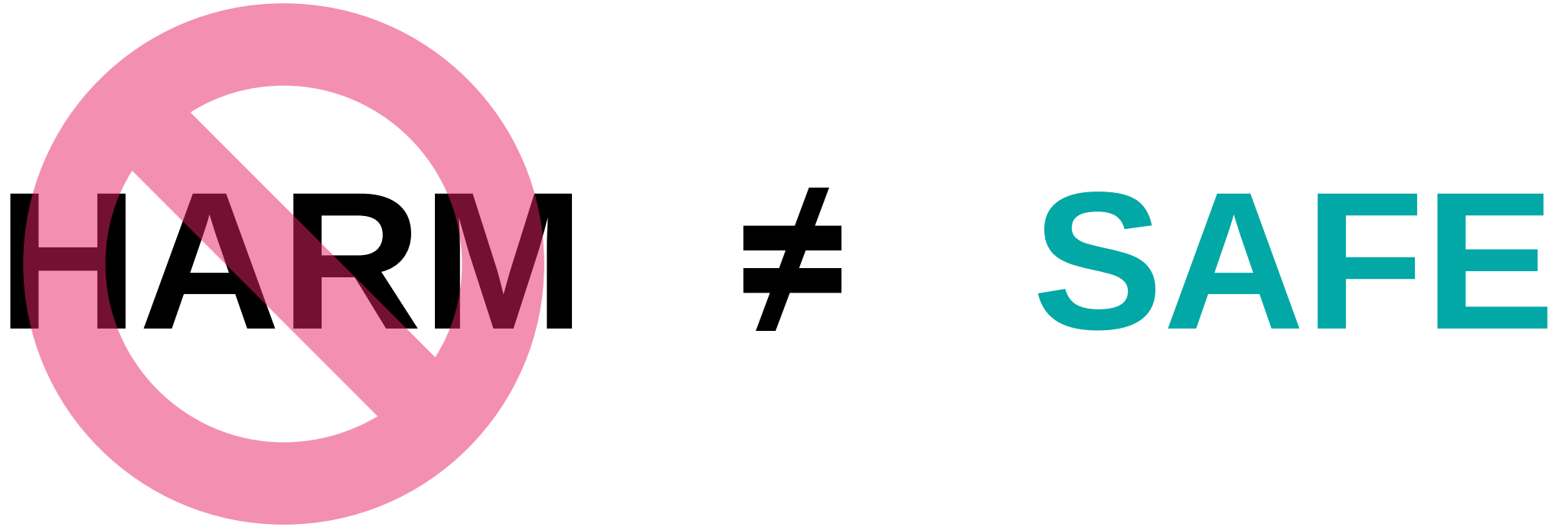
A disproportionate burden of harm is faced by patients who are vulnerable to communication challenges



Improving patient safety and quality of care: Applying an equity lens to hospital harm | CIHI

https://www.healthcareexcellence.ca/en/news/engaging-patients-to-reduce-hospital-harm/

The absence of harm does not mean the presence of safety



Rethinking Patient Safety (healthcareexcellence.ca)



Everyone contributes to patient safety.

Together we must learn and act to create safer care and reduce all forms of healthcare harm.

Finding the balance:
Changing the way we think about safety

Moving beyond a

Focus on Past Harm



To include

Holistic and proactive approaches to safer care



Finding the balance:
Widening our view of harm

Moving beyond …

Physical safety and physical harm

Physical harms

(treatment-specific & general harm)

To include

Broader forms of harm

Broadening our understanding of healthcare harm: Activity card | Healthcare Excellence Canada



Finding the balance:
Moving us from assurance to a practice of inquiry

Moving beyond…

Assurance



To include

Practice of inquiry that encourages curiosity



Finding the balance:
Embracing the value that patients and care partners have in creating safety

Moving beyond…

Engaging with patients only after harm has happened



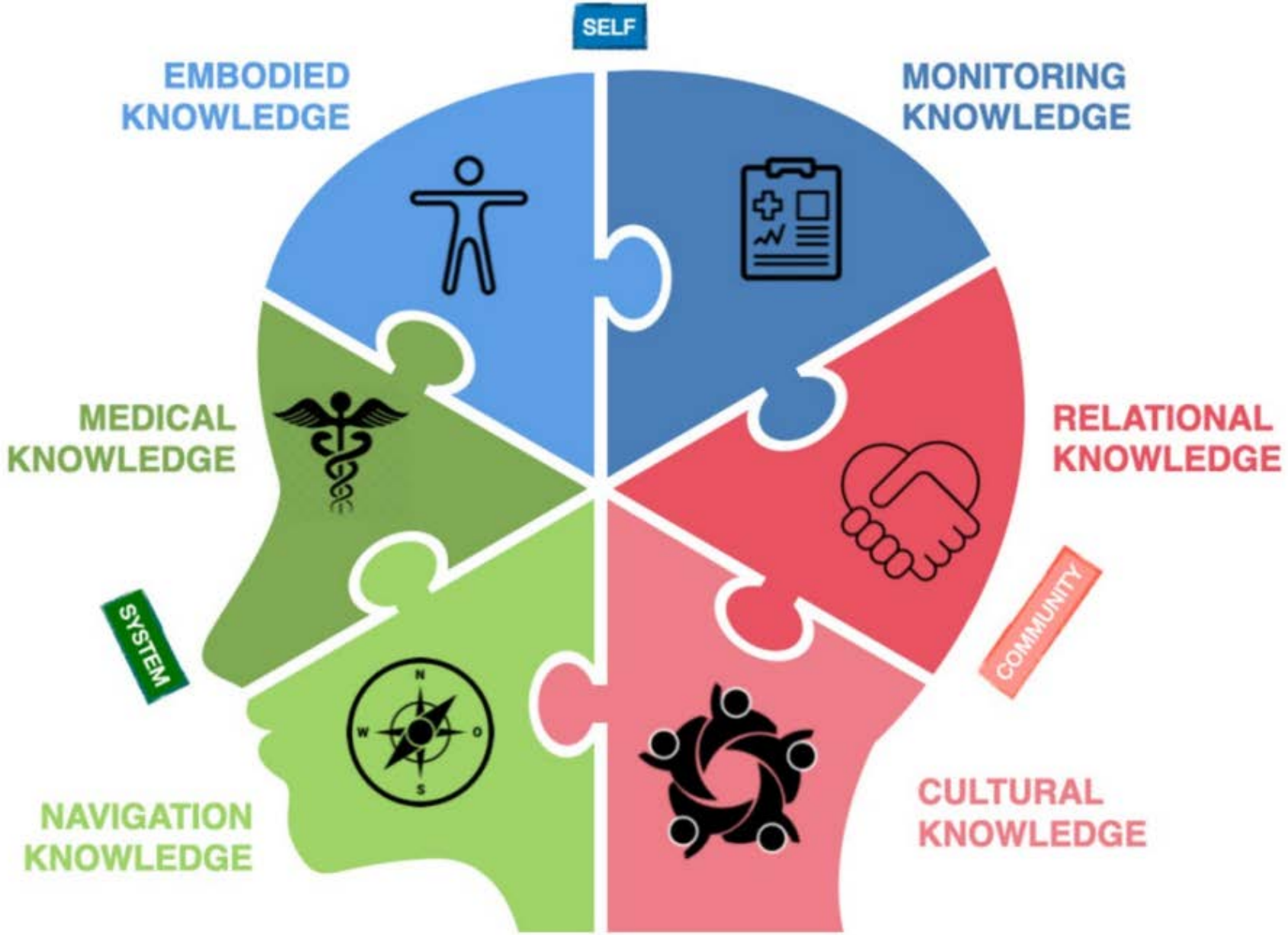
To include

Promoting the value that patients and care partners have in creating safety



Beyond experiential knowledge: a classification of patient knowledge

Dumez and L'Esperance, 2024. Social Theory and Health, 22, 173-186. [s41285-024-00208-3 (2).pdf]



Finding the balance:
Promoting everyone contributes to patient safety

Moving beyond

Safety as the responsibility of managers



To include

Empowering everyone to take a proactive role in safety



Finding the balance:

Promoting the value in things that are important but can’t be counted

Moving beyond…

Primarily focusing on the things, you can count



To include

The value soft intelligence

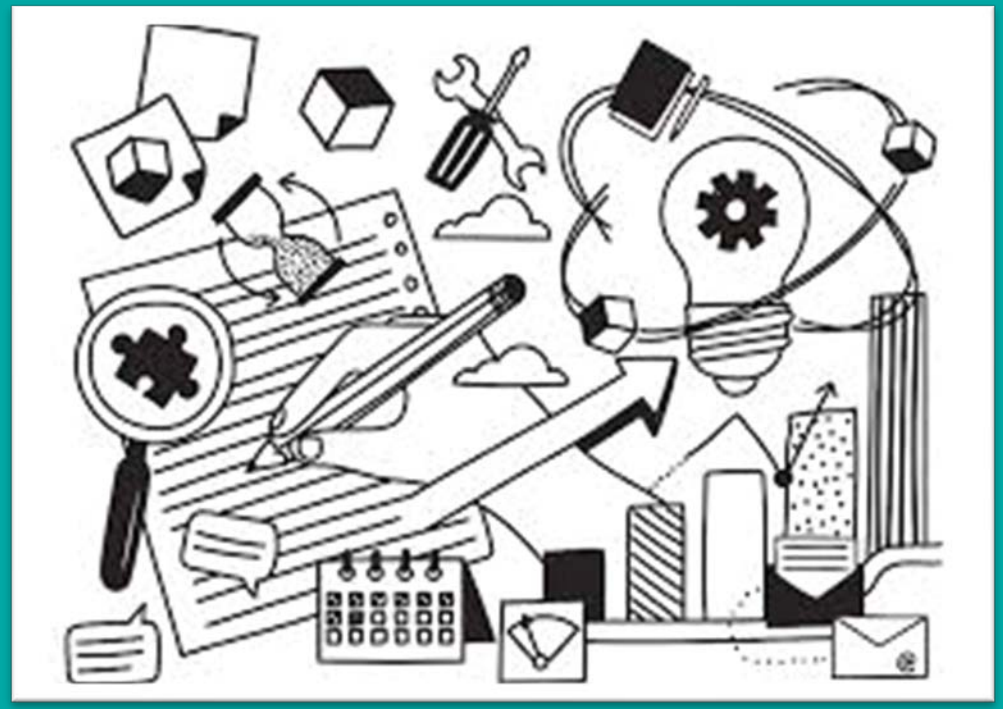


Finding the balance:

Recognizing that safety doesn't need to be an added burden, but rather a way of working

Moving beyond…

Safety being viewed as a project



To include

Safety as a way of thinking and acting



Finding the balance:
Promoting solutions beyond compliance strategies

Moving beyond…

Compliance strategies



To include

Safety solutions that are co-created with those who deliver and receive care



Preventing Harm

- Responsibility of managers and QI-safety departments
- Toolkits & checklists
- Score cards and audits
- Patient safety projects
- Incident management
- Committees
- Assurance & accountability
- Policies, rules & guidelines

Creating Safety

- Everyone contributes to safety
- A way of thinking, acting, responding
- Listening, observing and perceiving
- Coaching
- Proactively takes action
- Safety huddles and safety conversations
- Curiosity & Inquiry
- Actively seeks contributions of patients and care partners



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The Waterfall Chat:

What shapes safer care?

What is one thing you can do tomorrow to create safer care?



Keep the conversations going:

Questions you can ask your colleagues

What does patient safety mean to you?	How is the presence of safety different from the absence of harm?	Tell me about anything that alarmed or worried you during your delivery of care	Who do you speak to when you have a safety concern or compliment?
Is our care safe or are we just lucky?	How safe is our care?	What has made you feel unsafe at work (or since we last talked)?	What do you need to make you feel safe to raise concerns about safety?

Keep the conversations going:

Questions you can ask your clients and their care partners

- Who would you speak to if you didn't feel safe?
- What makes you feel safe?
- Tell me about anything that alarmed or worried you in the past 24 hours?
- What would make you feel safer?
- What makes you feel unsafe?
- What are your care preferences? (for example, 'what matters to you?')
- What has made you feel unsafe since we last talked?

Keep the conversations going:

Conversation starters for patients / residents / clients and care partners

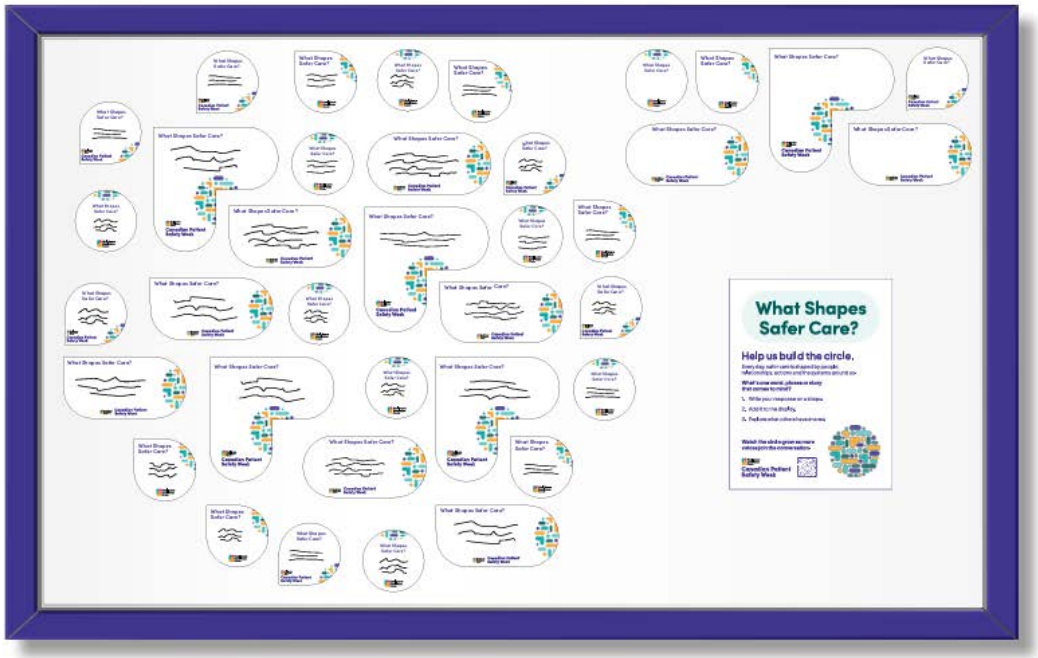
I would feel safer if…	I'm concerned about my or my loved one's condition because …	I am uncomfortable with my or my loved one's condition because …
I believe my safety or the safety of my loved one is at risk because...	I feel unsafe because…	What can I do to contribute to my safety?

Healthcare Excellence Canada

Canadian Patient Safety Week

What Shapes Safer Care?

Activity Guide



[What Shapes Safer Care? CPSW 2026 Activity Guide]

Build the foundations of safer care

The Foundations of Healthcare Excellence is a self-paced e-learning series and the recommended starting point for exploring core concepts that underpin healthcare excellence: engagement-capable environments, cultural safety, patient safety, and health equity.

Each module includes practical tools, guided reflection and discussion activities to help learners apply their learning within their own organization or care setting.

Together, the modules help build a shared understanding of the foundational concepts that support high-quality, safe and equitable care.

Start learning →



Patient Safety Essentials

A free, six module, self-directed program designed especially for healthcare providers to help you understand the core of patient safety.

Copy link



Event

Perspectives That Shape Safer Care: How can collaboration improve safety?

Join us for a special edition of the Spotlight Series, guided by this year's CPSW 2026 theme. Explore how collaboration across the system influences the quality and safety of care.

When 12:00 - October 29, 2026

EN-First

Spotlight Series

Webinar

Blogs

Shaping Safer Care Through Partnership

Every year, World Patient Safety Day provides an important opportunity to recognize patient safety as a global health priority and reflect on what each of us can do to make care safer.

Date September 17, 2026

Partnership



More from HEC

HealthcareExcellence.ca | ExcellenceSante.ca

Creating safer care. Together.



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HealthcareExcellence.ca | ExcellenceSante.ca

CarePartners

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When Noticing Change Shapes Safer Care





Community Support Worker (CSW), Jackie, works at a home care agency providing care on behalf of Ontario Health atHome. She provides care three times per week for **Margaret, who is 87 years old.** Margaret has diabetes, arthritis, decreased mobility, and a history of falls.
Margaret lives alone, values her independence, and wants to continue living safely in her own home.

The care plan states that Jackie is to assist with personal care, a shower, transferring, and a bit of tidying as time allows.

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During Today's Visit, Jackie Notices…

01 **Change in Condition**
Margaret is more confused than usual and moving more slowly

02 **Mobility Aid**
Margaret's walker is across the room from her

03 **Tripping Hazard**
A small throw rug has shifted into her usual walking path

04 **Footwear Concern**
Margaret is not wearing her nonslip slippers



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The question is:

“What am I noticing, and what can I do to prevent harm while respecting Margaret's choices?”



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Shaping Safer Care Through Everyday Actions

Jackie’s agency trains frontline workers to identify home hazards and changes in a patient’s condition that may increase fall risk, including dizziness, confusion, or unsteadiness. The agency uses the **Weight-bearing Check** and the **OCAR** model of care.

Weight-bearing Check: Patient’s must be able to bear weight for 5 seconds with support (walker/cane), without falling or their legs weakening and giving out.

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OCAR Method: Observe - Coach - Assist - Report

Applying OCAR:

O | **Observe**
What am I seeing, hearing, or noticing?

C | **Coach**
How can I help the patient understand and reduce the risk?

A | **Assist**
What can I do safely within my role and the care plan?

R | **Report**
What does the care team need to know?

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Applying Requirements to Margaret's Care

After addressing the environmental hazards, Jackie notices that Margaret appears slightly more unsteady when standing. She applies her training by completing the required **Weight-bearing Check** and follows the **OCAR** model of care before proceeding with care.

Let’s Ask Ourselves: What Would YOU Do?



- What would you **Observe**?
- How could you **Coach** Margaret without taking away her independence?
- What could you **Assist** with within your role?
- What would you **Report**?
- What could happen if nobody speaks up?

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O | Observe

What do you see, hear & sense?

Jackie identified potential risks and patients such as:

- Margaret appears different from usual
- Her walker isn't within easy reach
- There is a potential tripping hazard
- Margaret is not wearing appropriate footwear
- Margaret communicated that maintaining her independence is important to her



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C | Coach

How can you help the patient understand and reduce the risk?

Jackie has a conversation with Margaret:
“Margaret, I noticed you're a little less steady than usual this morning. What are you noticing?”

“Would you be okay if we moved your walker closer and moved this rug out of your walking path?”

This gives Margaret a voice in her care while opening a conversation about safety.

A | Assist

What can you do safely within your role and the care plan?

Take appropriate action within the CSW role and care plan:

- Jackie supports Margaret with her planned care while considering the risks that have been identified, including ensuring that the mobility aid is available when needed.

- Jackie's agency training specifically describes assisting clients to perform activities of daily living safely and following the care plan to reduce identified risks.

R | Report

What does the care team need to know?

Don't let the observation end when the visit ends:

- Jackie reports the safety concern and changes observed to her manager, following her agency's reporting expectations.

- Jackie's manager requested an assessment be completed by Ontario Health atHome with the patient and spoke to the patient and her family to notify them that the care coordinator would be notified.

- The manager ensured the other team members were aware of the patient's changes.

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What Shapes Safer Care?



Safer care is shaped by the actions you take every day!

It’s not about eliminating every risk. It’s about noticing what has changed, listening to the patient, recognizing when something doesn’t seem right, and taking action within your role.

A small change noticed. A concern heard. A risk reported. A safer outcome made possible.

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Discussion / Q&A



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Visit our Project ECHO PSW page for more information about upcoming sessions:



Before the Next Dose

The PSW's Role in Medication Safety at Home

For the Record

Noticing Changes and Knowing When to Escalate

cdnhomecare.ca/chca-project-echo-personal-care-providers