Health PEI

Summer 2025

Quality & Patient Safety Quarterly Review

Fall Quality and Patient Safety Learning Exchange

UNCOVER A FRESH DOSE OF KNOWLEDGE!

The **Health PEI Quality and Patient Safety Learning Exchange** is a half-day event aimed at bringing together staff, physicians, leaders, Board members, and community partners to connect and delve into quality improvement and patient safety initiatives at Health PEI.

Event Details

- **Date**: Thursday, October 30, 2025
- **Time**: 1:00 PM to 4:00 PM
- **Location**: Credit Union Place, Summerside

Participants can look forward to engaging Rapid Fire Presentations, as well as information booths and posters that highlight various programs and services.

To confirm your attendance, please email Catherine Coady at **cacoady@ihis.org** by **October 15, 2025.**

If you have quality improvement or patient safety projects you'd like to present at a future Learning Exchange, please contact your program's Quality Patient Safety Consultant. Poster presentations and information booths are also encouraged!

Spring Learning Exchange – A Resounding Success!

On May 29, 2025, over 150 staff, physicians, leaders, and community partners gathered at Florence Simmons Hall for the Spring Quality and Patient Safety Learning Exchange.

The event featured:

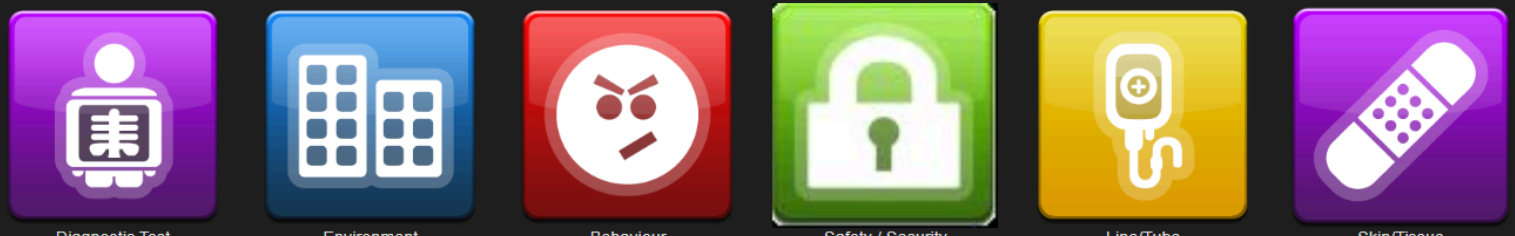
- Rapid Fire Presentations showcasing frontline innovations
- Poster Displays highlighting improvement projects
- Networking Opportunities to share ideas and build momentum

What People Had to Say!

"Learning about the positive changes happening in the system. Great venue. Great snacks. Great booths."

" The short and snappy sessions!"

"Celebration of successes and good news! Representation of diverse initiatives and various aspects of the organization "



From Patient Safety Incident to Action

What Happens After You Report a Patient Safety Incident

At Health PEI, reporting of patient safety incidents through the Provincial Safety Management System (PSMS) is a vital step in promoting a culture of safety and continuous improvement. But what happens after you click "submit"? Here's a look behind the scenes:

① Immediate Triage and Review

Once a patient safety incident is submitted, it is automatically routed to the appropriate manager or designate for the program service area where it occurred. They review the submission to assess:

- The severity of the patient safety incident
- Whether immediate action is required
- If any harm occurred to patients, staff, or visitors

② Follow-Up and Investigation

Depending on the nature of the patient safety incident, the manager or designate may:

- Conduct a preliminary review or formal investigation
- Interview involved staff
- Review documentation and relevant policies
- Identify contributing factors

For more serious or complex patient safety incidents, the **Quality and Patient Safety** team may become involved to support a system-level review.

③ Documentation and Analysis

Manager/designate follow-up actions are documented in PSMS. This ensures transparency and allows for:

- Trend analysis
- Identification of recurring issues
- System-wide learning opportunities

④ Feedback and Communication

Where appropriate, manager/designate will inform staff involved in the incident on:

- The outcome of the review
- Any changes made as a result
- Opportunities for learning or improvement

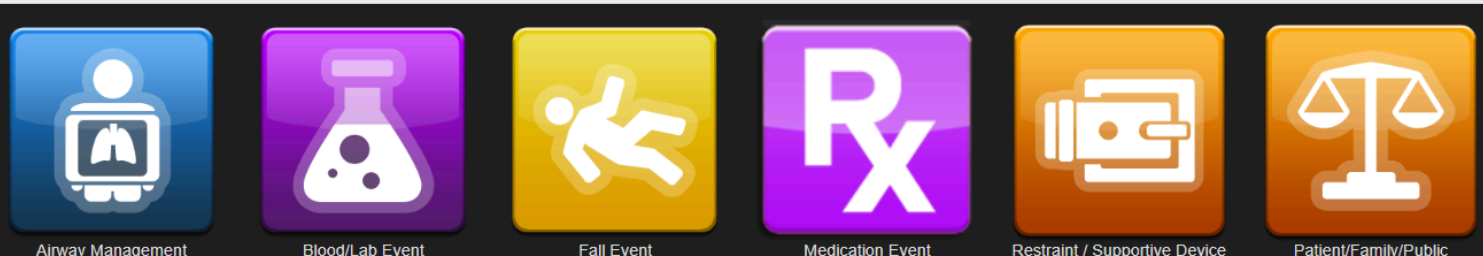
This step is crucial in closing the loop and reinforcing a just culture.

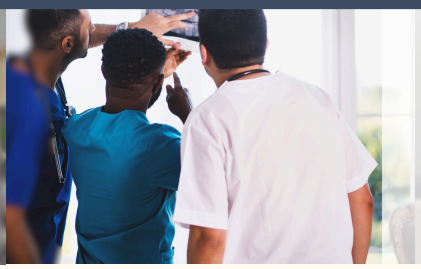
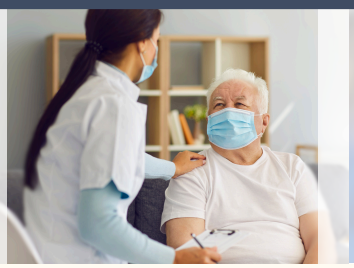
⑤ System Improvements

System learnings from patient safety incidents are used to:

- Update policies and procedures
- Inform training and education
- Guide quality improvement initiatives

Remember: Reporting of patient safety incidents is about system learning. Every patient safety incident helps us build a safer, more responsive healthcare system for everyone.




Just Culture Corner

From Blame to Balance: Building Trust Through Just Culture

In healthcare, mistakes can carry heavy consequences—not just for patients, but for the professionals involved. That's why fostering a **Just Culture** is more than a philosophy; it's a critical component of safe, high-performing organizations.

A **Just Culture** understands that people make mistakes, it's part of being human. That's why it focuses on building effective systems that help to prevent those errors from happening in the first place. It encourages open reporting, learning from incidents, and distinguishing between human error, at-risk behavior, and reckless conduct.

When staff feel safe to speak up without fear of punishment, they're more likely to report near misses and adverse events. This transparency is the foundation for continuous improvement and safer care.

Quick Tip:

Next time an incident occurs, ask:

- Was this a system issue, a behavioral choice, or a knowledge gap?
- How can we support learning rather than assigning blame?

Let's continue to shift the conversation from "Who is at fault?" to "What went wrong, and how can we fix it?"

For further information or to access training, contact **Christine Handrahan,** Project Manager
christinehandrahan@ihis.org
902-218-6303

*Stay tuned for next month's Corner, where we'll explore how **Just Culture** understands and approaches accountability.*

Ethics in Action

Are you looking for a new and interesting way to contribute to our health system?

The **Health PEI Clinical and Organizational Ethics Committee (C&O)** is looking for new members. The committee supports ethics-related issues and consultations, as well as education for the organization.

The committee meets virtually each month for an hour, welcoming members to participate in ethics consultations as well as assisting with education throughout the health system. This is a great opportunity to learn more about ethics and contribute to an environment where ethical dilemmas can be proactively identified and addressed.

If you are interested in this opportunity, please contact the **Health PEI C&O Ethics Committee** at **clinicalethics@ihis.org**

National Health Ethics Week is taking place **November 3-7th, 2025**.
Stay tuned for more information.

Understanding the PDSA Cycle

The **Plan-Do-Study-Act (PDSA) Cycle** is a cornerstone of continuous quality improvement in healthcare. It's a simple yet powerful framework used to test changes in real-world settings, helping teams improve processes, enhance patient safety, and deliver better care.

What is the PDSA Cycle?

- **Plan:** Identify an area for improvement and develop a plan to test a change. Define objectives, predictions, and a clear strategy for implementation.
- **Do:** Carry out the plan on a small scale. Document what happens and begin collecting data.
- **Study:** Analyze the results. Compare the data to your predictions and reflect on what was learned.
- **Act:** Decide whether to adopt the change, adapt it for further testing, or abandon it. Use insights to inform the next cycle.

Why It Matters:

The **PDSA Cycle** encourages incremental learning, team collaboration, and evidence-based decision-making. It's especially useful in clinical settings where small changes can lead to significant improvements in patient outcomes and system efficiency.

Real-World Example:

A unit might use the **PDSA Cycle** to improve hand hygiene compliance. After planning and testing a new reminder system, they study the impact and refine the approach before rolling it out more broadly.

Welcome our Provincial Patient Navigator, Doreen Pippy

Doreen Pippy graduated from the University of Prince Edward Island (UPEI) with both a Bachelor of Arts in Psychology and a Bachelor of Science in Foods and Nutrition. Her career as a healthcare professional began out-of-province, where she worked as a Registered Dietitian and Certified Diabetes Educator in The Pas, Manitoba, and Sudbury, Ontario.

Since returning to PEI in 2015, Doreen has held various positions within Health PEI, demonstrating her versatility and commitment to patient care across a wide range of departments. Her experience spans Diabetes Education, Ambulatory Care, Mental Health, Palliative Care, Home Care, Public Health, and Primary Care.

Throughout her diverse career, Doreen has consistently found immense satisfaction in helping individuals understand their healthcare journey. This passion aligns perfectly with her new role as a Provincial Patient Navigator, where she will undoubtedly be a valuable resource for patients navigating the healthcare system in PEI.

Accreditation Update

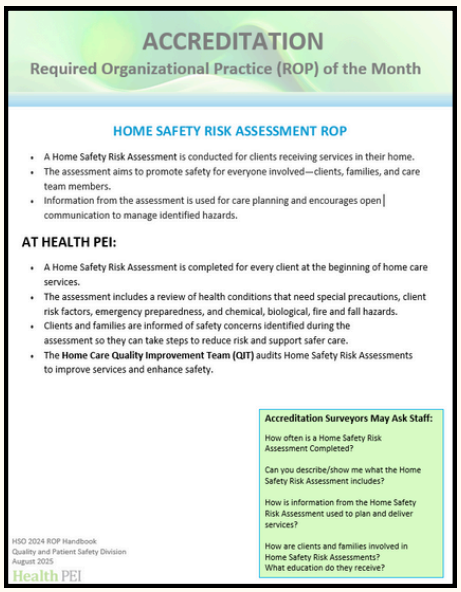
Only **291** Days Until the Next Onsite Survey!

The **Quality and Patient Safety Division** is actively preparing for the upcoming **Accreditation Canada** onsite survey, scheduled for **June 7–12, 2026**. This system-wide assessment will see surveyors—experienced health care professionals from other organizations—visit various sites and programs to evaluate our care and services against 25 sets of national standards and **Required Organizational Practices (ROPs)**.

Survey Preparation in Full Swing

To enhance readiness efforts, the **Quality and Patient Safety Division** has introduced several initiatives:

- **ROP of the Month & Did You Know Documents:** Distributed monthly via email and available on the Staff Resource Centre and Quality Patient Safety Dashboard, these highlight key accreditation and quality improvement topics. Leaders and staff are encouraged to display them on local quality boards.
- **Patient Safety Walks:** Ongoing visits that focus on ROPs like infusion pump safety, medication use, and hand hygiene, supported by Quality Patient Safety Consultants (QPSCs) to identify patient safety improvement opportunities.
- More resources and tracer tools will be available in Fall 2025!


ACCREDITATION

Required Organizational Practice (ROP) of the Month

HOME SAFETY RISK ASSESSMENT ROP

- A Home Safety Risk Assessment is conducted for clients receiving services in their home.
- The assessment aims to promote safety for everyone involved—clients, families, and care team members.
- Information from the assessment is used for care planning and encourages open communication to manage identified hazards.

AT HEALTH PEI:

- A Home Safety Risk Assessment is completed for every client at the beginning of home care services.
- The assessment includes a review of health conditions that need special precautions, client risk factors, emergency preparedness, and chemical, biological, fire and fall hazards.
- Clients and families are informed of safety concerns identified during the assessment so they can take steps to reduce risk and support safer care.
- The **Home Care Quality Improvement Team (QIT)** audits Home Safety Risk Assessments to improve services and enhance safety.

Accreditation Surveyors May Ask Staff:

How often is a Home Safety Risk Assessment Completed?

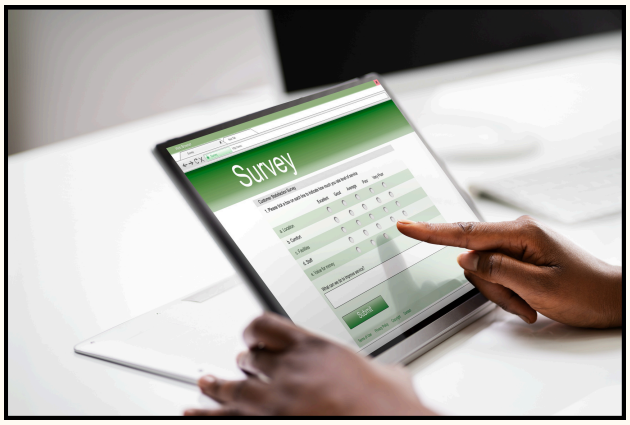
Can you describe/show me what the Home Safety Risk Assessment includes?

How is information from the Home Safety Risk Assessment used to plan and deliver services?

How are clients and families involved in Home Safety Risk Assessments? What education do they receive?

HSO 2024 ROP Handbook
Quality and Patient Safety Division
August 2025

Health PEI



Canadian Patient Safety Culture Survey – Launching September 2025

Understanding safety culture is key to improving care quality. This September, the **Quality and Patient Safety Division** will launch the **Canadian Patient Safety Culture Survey** (Can-PSCS) to collect staff views on patient safety and incident reporting.

Survey Highlights:

- **Participants:** Staff, leaders, and physicians in all care settings, including:
  - Clinical roles (nurses, physicians, allied health)
  - Direct care roles (resident/patient care workers)
  - Support departments (lab, environmental services)
  - Leadership roles (nurse/care managers, senior leaders)
- **Anonymity:** No names are collected.
- **Completion:** Online via a link sent through all-staff email in September.
- **Time Commitment:** About 15–20 minutes for 23 questions.

Questions?

Reach out to **Karen Chaffey**, Acting Director of Quality Care, Accreditation & Ethics:

kkchaffey@ihis.org

Making Quality Visible: How to Build an Effective Quality Board

In the fast-paced world of healthcare, where patient safety and continuous improvement are paramount, **Quality Boards** serve as powerful visual tools to align teams, track progress, and foster a culture of transparency and accountability.

But what exactly makes a **Quality Board** great—not just good?

A **Quality Board** is a dynamic visual tool that enhances engagement, transparency, and accountability in continuous improvement across various sectors. Its main goals include:

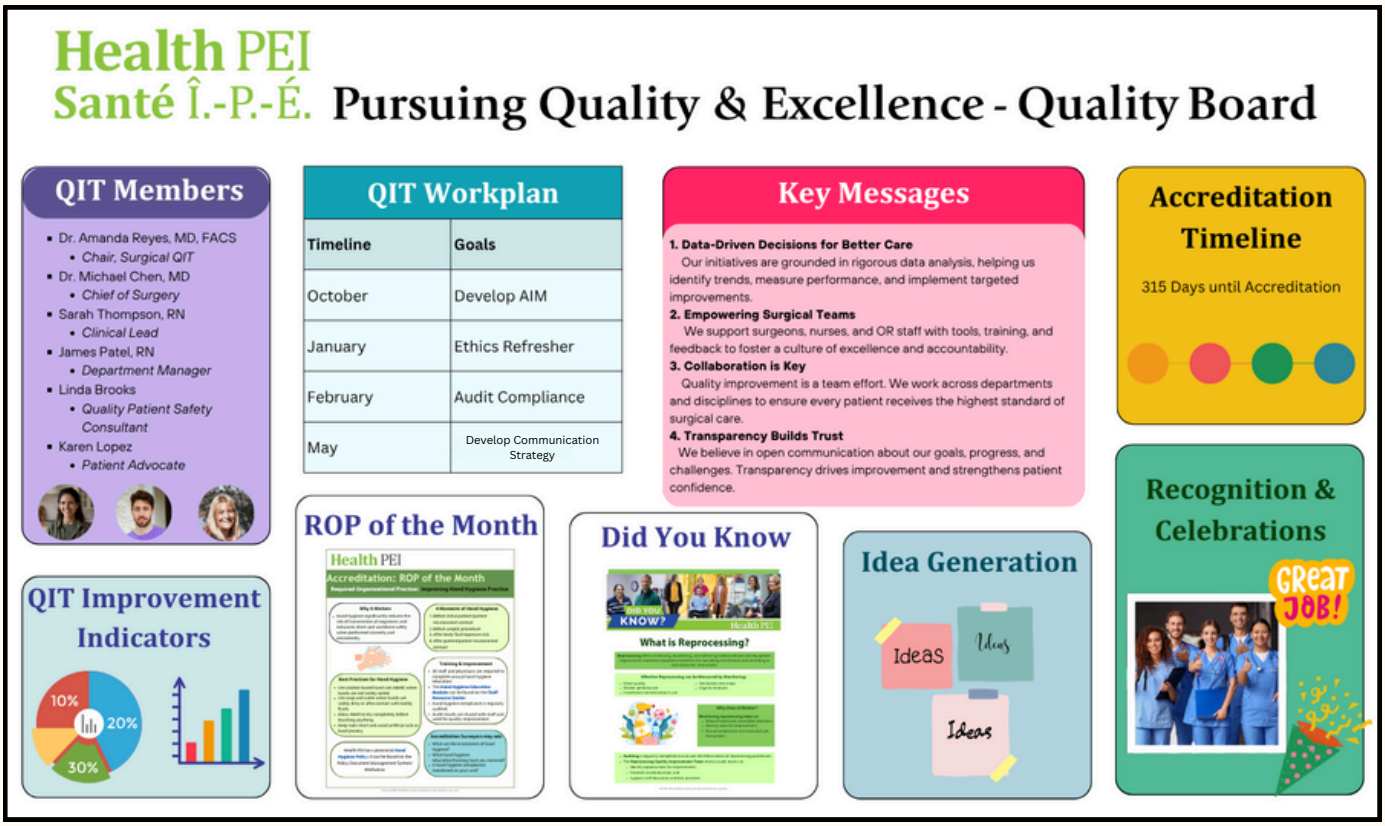
- Visualizing progress on initiatives
- Engaging teams in problem-solving
- Tracking key metrics
- Fostering communication and collaboration
- Celebrating successes and learning from setbacks

Essential Components of a Quality Board:

- Health PEI Banner (If you need one contact your Quality Patient Safety Consultant)
- QIT Member List and Titles
- QIT Workplan
- QIT Indicators Data
- Key Messages from QIT Meetings
- Accreditation Time Line
- ROP of the Month and Did You Knows

Optional Components:

- Idea Generation Section for staff input
- Recognition and Celebrations for team achievements and contributions



Additional Notes

- Boards should be updated monthly
- Include visuals – charts, graphics, and images help to capture people's attention
- Assign a team member to be responsible for updating the board monthly

For additional support contact your Quality Patient Safety Consultant

CELEBRATING OUR PATIENT EXPERIENCE STARS!

*From left: Jenn Snodgrass, Dr. Friedrich, **Ellen Glendinning STAR**, Tanya Murphy*

We're thrilled to announce the recipients of this year's Patient Experience Star Award — a recognition of staff who go above and beyond to create meaningful, compassionate, and collaborative care experiences.

During Patient Experience Week health care staff were invited to nominate co -workers to be identified as a "**STAR**" in their work area.

*From left: Ileana Clow, **Brad Scheuermann STAR**, Tanya Murphy*

Staff were so excited, they nominated close to 100 Health PEI Nurses, Physicians, Allied Health, Support Staff, Managers and Leaders. 22 staff members were celebrated as Stars. We arranged to do surprise visits to the "Star" and their managers and coworkers helped in the celebration.

Oladiipo Taiwo STAR

*From left: Tanya Murphy & **Kathryn Roberts STAR***

*From left: Tanya Murphy, **Elaine Swan STAR**, Aletha MacNevin*

*From left: Kim McPhee, **Frank Connolly STAR**, Kimberly Hagen*

*From left: Natalie Dooks, Tanya Murphy, **Trina Tremere STAR**, Melanie Walsh, Colleen Dunn*

*From left: **April Mills STAR** & Kimberly Hagen*

*From left: Jan Skeffington, **Reanne Bradley STAR, Nicolle Downey STAR**, Tanya Murphy*

*From left: Kimberly Hagen, Olivia MacDonald, **Leona McIntosh STAR**, Melanie Walsh*

CELEBRATING OUR PATIENT EXPERIENCE STARS!

*From left: Kimberly Hagen, **Wendy Wheeler STAR, Deborah Sheilds STAR**, Steven Cassell. Missing from photo: **STARS Sheri Wight, Serena Seely, Jill MacDonald, Cheryl Perry***

*From left: Kimberly Hagen, **Nancy Murphy STAR**, Colleen VanWestemeng*

*From left: Melody Collicutt, **Rhonda Lynch-McLean STAR**, Kimberly Hagen*

*From left: Tanya Murphy & **Deanna Chaisson STAR***

*From left: Tanya Murphy & **Megan Nicholson STAR***

*From left: Kimberly Hagen, **Andrea MacDonald STAR,** Verley Harrison*

*From left: **Shelley Edwards-Dick STAR**, Tanya Murphy, **Laurie Shea STAR***

*From left: **Dr. Joanne Reid STAR** & baby Brendel*

*From left: Kimberley Hagan, **Barbara MacPhee STAR**, Erin Campbell-Moore*

Thank you to everyone who submitted nominations—and congratulations to our incredible **STARs**. Your dedication makes a lasting impact on patients, families, and colleagues alike.

*From left: Melanie Walsh, Brianne Kiley, **Dr. Lecours STAR, Blanche Ward STAR**, Kimberly Hagen*

Nominate a Health PEI Patient Safety Champion before **October 10, 2025**

Do you know someone at your workplace who deserves recognition for promoting patient/client/resident safety? You can nominate them to be recognized as a **Health PEI Patient Safety Champion.**

A **Patient Safety Champion** is any Health PEI staff member who proactively identifies areas for improvement in their department/program and works to implement changes that promote patient safety.

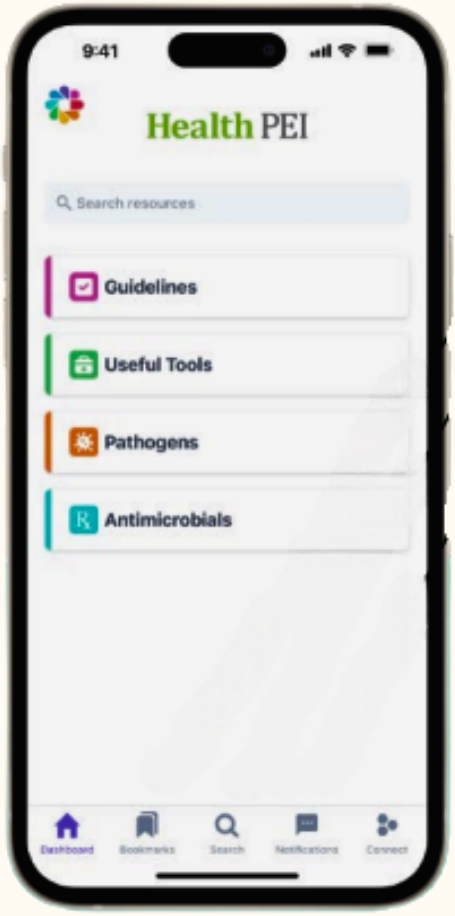
During **Canadian Patient Safety Week from October 27 to 31, 2025**, the Quality and Patient Safety Division will honor Health PEI **Patient Safety Champions**, who will receive prizes and have their achievements highlighted in future communications.

Some criteria for recognizing a Patient Safety Champion at your workplace are:

- Encourage patient and family engagement in safety discussions
- Welcome participation to enhance person and family-centered care
- Use two specific identifiers for accurate patient identification
- Foster positive relationships and cultural safety
- Communicate complete information during care transitions
- Prevent harmful incidents, like wrong-person procedures
- Avoid dangerous abbreviations to reduce documentation errors
- Enhance safety for high-alert medications
- Model proper PPE use and hand hygiene
- Reduce risks of falls and behavioral events
- Promote safe medication administration practices
- Identify risks proactively to prevent harm
- Maintain comprehensive patient records for smooth transitions
- Investigate and follow up on safety incidents thoroughly.

Click to Nominate

Firstline App: Smarter Stewardship at Your Fingertips



Antimicrobial resistance is a growing challenge—but with the **Firstline app**, Health PEI providers have a powerful tool to support better, faster treatment decisions. This free app delivers customized, evidence-based infectious disease guidelines right to your device, helping you practice effective antimicrobial stewardship at the point of care.

Why Use Firstline?

- Access Health PEI's local guidelines, dosing info, antibiograms, and IPAC resources
- Use tools like IV-to-PO step-down and Beta-Lactam allergy guidance
- Bookmark frequently used content and search easily within documents
- Receive alerts when guidelines are updated

What's New?

- Updated guidelines for pneumonia (all types), AECOPD, and febrile neutropenia
- New "Stewardship Spotlight Education" section
- **Coming soon:** Adult Influenza guideline and penicillin allergy de-labeling tool

Download it today on iOS, Android, or use the desktop version (pre-installed on all Health PEI computers).

Questions? Contact **Fiona Mitchell**, Antimicrobial Stewardship Pharmacist at **fcmitchell@ihis.org**

Do you have any questions regarding the information you've read here? Would you like to propose a topic or story idea for an upcoming edition of the newsletter? If so, feel free to reach out to **Catherine Coady** at **cacoady@ihis.org**

The Staff Resource Centre (SRC) homepage includes a Quality and Patient Safety section that highlights essential information regarding accreditation, enhancement, safety, and ethics. Staff members are encouraged to visit this section regularly for the latest updates.

EMAIL CATHERINE

STAFF RESOURCE CENTER

The Quality & Patient Safety Quarterly Review is brought to you by the Quality, Patient Safety and Ethics Division