PHYSICIAN QUALITY IMPROVEMENT
An SSC Initiative

Improving MINS Monitoring

Better Screening for Myocardial Injury after Non-cardiac Surgery

PROJECT TEAM

Project Lead:
Dr. Kevin Yee, MD, Anesthesiologist

Project Participants:
- Rosie Holmes, PQI Coordinator
- Curtis Bilson, PQI Data Analyst
- Dr. Stephen Head, MD, Anesthesiologist

BACKGROUND

- 1:20 patients coming undergoing noncardiac surgery experiences either myocardial injury, myocardial infarction, or cardiac death perioperatively
- Perioperative cardiac complications are responsible for 1/3 of perioperative deaths
- Patients older than 65 years of age or those that have at least one risk factor for perioperative myocardial infarction should be screened with NT-proBNP preoperatively

PROBLEM

- Patients that should be monitored as per the latest *Canadian Cardiovascular Society Guidelines* are being missed
- The process for anesthesiologists to ensure patients are being monitored may be too difficult

AIM STATEMENT

- **What –** Increase the preoperative screening for *Myocardial Injury after Non-cardiac Surgery* (MINS)
- **For whom –** Surgical patients 65 years or older that stay in hospital for at least 24 h ours
- **By when –** April 2018
- **How much –** Increase by 50%

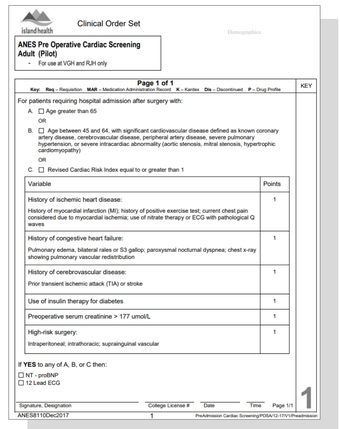
PATIENT VOICE

I never knew a heart attack could be silent.

Thank you for making sure that my surgery and recovery goes smoothly

CHANGE IDEA

- Facilitate MINS monitoring by introduction of streamlined order sets and tracking forms
- Increase awareness of MINS protocol via presentations at rounds
- Development of MINS protocol infographic to display for staff



Clinical Order Set

ANES Pre Operative Cardiac Screening Adult (Pilot)
- For use at VGH and RJH only

Page 1 of 1

Key: Req – Requisition MAR – Medication Administration Record K – Kardex Dis – Discontinued P – Drug Profile

KEY

For patients requiring hospital admission after surgery with:

A. ☐ Age greater than 65
OR
B. ☐ Age between 45 and 64, with significant cardiovascular disease defined as known coronary artery disease, cerebrovascular disease, peripheral artery disease, severe pulmonary hypertension, or severe intracardiac abnormality (aortic stenosis, mitral stenosis, hypertrophic cardiomyopathy)
OR
C. ☐ Revised Cardiac Risk Index equal to or greater than 1

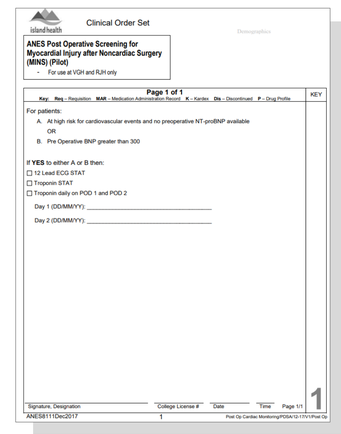
Variable	Points
History of ischemic heart disease: History of myocardial infarction (MI); history of positive exercise test; current chest pain considered due to myocardial ischemia; use of nitrate therapy or ECG with pathological Q waves	1
History of congestive heart failure: Pulmonary edema, bilateral rales or S3 gallop; paroxysmal nocturnal dyspnea; chest x-ray showing pulmonary vascular redistribution	1
History of cerebrovascular disease: Prior transient ischemic attack (TIA) or stroke	1
Use of insulin therapy for diabetes	1
Preoperative serum creatinine > 177 umol/L	1
High-risk surgery: Intraperitoneal; intrathoracic; suprainguinal vascular	1

If **YES** to any of A, B, or C then:
☐ NT - proBNP
☐ 12 Lead ECG

Signature, Designation | College License # | Date | Time | Page 1/1

ANES8110Dec2017 1 PreAdmission Cardiac Screening/PDSA/12-17/V1/Preadmissior

1



Clinical Order Set

ANES Post Operative Screening for Myocardial Injury after Noncardiac Surgery (MINS) (Pilot)
- For use at VGH and RJH only

Page 1 of 1

Key: Req – Requisition MAR – Medication Administration Record K – Kardex Dis – Discontinued P – Drug Profile

KEY

For patients:

A. At high risk for cardiovascular events and no preoperative NT-proBNP available
OR
B. Pre Operative BNP greater than 300

If **YES** to either A or B then:
☐ 12 Lead ECG STAT
☐ Troponin STAT
☐ Troponin daily on POD 1 and POD 2

Day 1 (DD/MM/YY): _____

Day 2 (DD/MM/YY): _____

Signature, Designation | College License # | Date | Time | Page 1/1

ANES8111Dec2017 1 Post Op Cardiac Monitoring/PDSA/12-17/V1/Post Op

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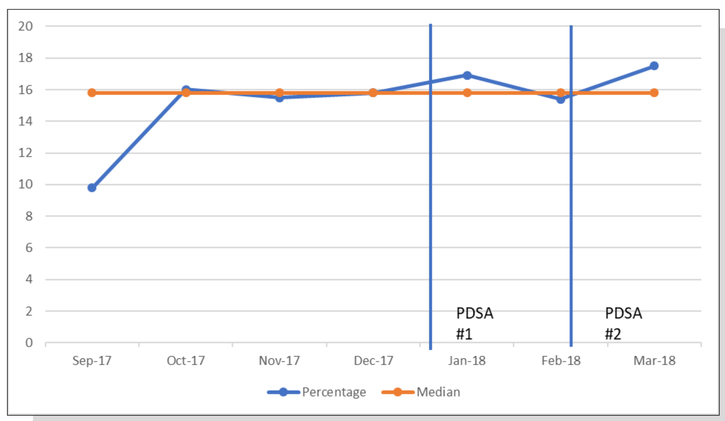
Image 1: Preoperative Screening Orders

Image 2: Postoperative Monitoring Orders

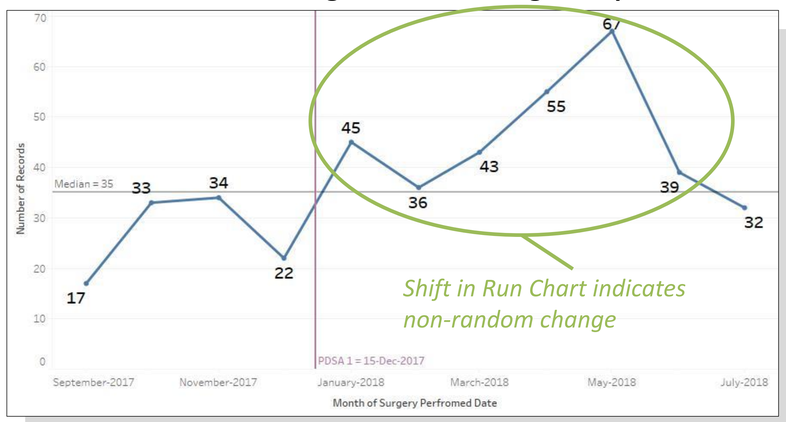
DATA ANALYSIS

- **Patient Group**: All patients 65 years of age or older having elective surgery with planned overnight admission at Royal Jubilee Hospital were captured on a monthly basis
- **Data Collection:** Patients were analyzed via the Cerner clinical database to determine if they received an NT-proBNP test before their surgery
- **Data Analysis:** Percentage of patients receiving NT-proBNP were plotted on Run Chart
- **Anesthesiologist Survey:** regarding awareness and usefulness of MINS protocol

Percentage of Patients Aged 65+ Receiving Pre-op BNP



Number of Patients Aged 65+ Receiving Pre-op BNP



PROJECT SPREAD

- Ensure department leaders of groups involved are notified
- Outreach via visiting presentations, emails to groups, and creation of posters to increase awareness

FINDINGS

- Effective change is difficult from one intervention alone; multiple opportunities for PDSA cycles will occur from feedback
- Outreach and promotion of changes is extremely important
- Project now awaiting results of second PDSA

CONCLUSION

- Postoperative myocardial injury after noncardiac surgery is an ever expanding area of research interest. Despite growing body of evidence that the presence of MINS causes at least a 3-fold increase in morbidity and mortality, many patients are still not being adequate captured for closer monitoring.
- With continued data collection and monitoring, regular education directed at involved medical staff groups, and potential automation of patient screening and monitoring will be key interventions in ensuring that high risk patients are adequately monitored for cardiac complications.

SPECIALIST SERVICES COMMITTEE

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Improving Preterm Labour Testing
an Evidence-based & Data-driven Approach

PQI PHYSICIAN QUALITY IMPROVEMENT
An SSC Initiative

PROJECT TEAM

Michael Chen, MD, Lab Medicine, Project Lead
Diane Sawchuck, RN
Hayley Bos, MD, OB/GYN
Jaideep Kanungo, MD, Pediatrics
Sam Kohen, MD

AIM STATEMENT

-To assess the diagnostic accuracy of the phIGFBP-1 (Actim Partus) test and the fFN test for spontaneous preterm birth in symptomatic women on Vancouver Island.
-To optimize the diagnostic workup to improve quality of care and cost effectiveness
-To make recommendations to BC Lab Agency Utilization Management Committee (UMC) to update the 2005 provincial guideline for preterm labour testing.

Study Design

Data-driven, evidence-based approach

Local lab data
(VIHA 2008-2017)

Cerner VALIDATED

New relational database



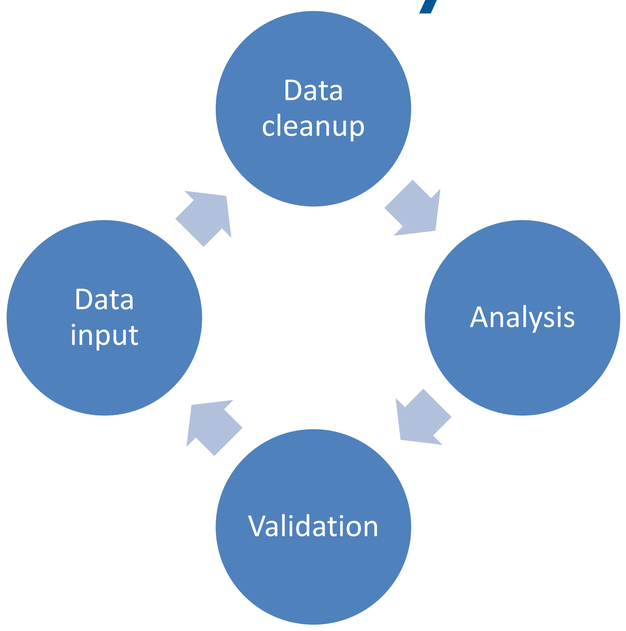


BC Perinatal Registry
(PHSA 2008-2017)

BACKGROUND

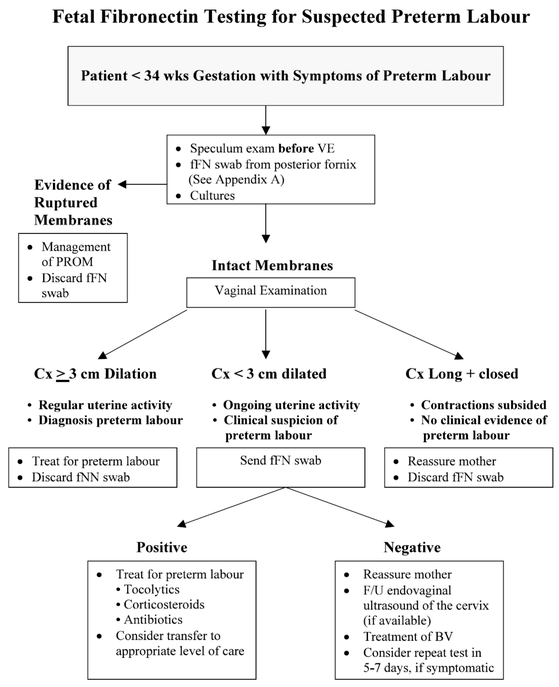
-Preterm delivery (PTD) is defined as birth before 37 weeks of gestation. In Canada, PTD occurs in ~ 8% of all pregnancies. PTD is also the leading cause of neonatal mortality and morbidity. However, only 20% of women presenting with suspected preterm labour (PTL) would deliver preterm.
-Early detection of PTL and accurate prediction of PTD are crucial because they enable the use of effective treatment, targeted referrals and avoid unnecessary interventions.
-Two biochemical tests, fetal fibronectin (fFN) and Actim Partus, are available to exclude delivery within 7 days.
-Island Health has offered both tests from 2008-2017 to all patients presenting with suspected PTL.

PDSA Cycle

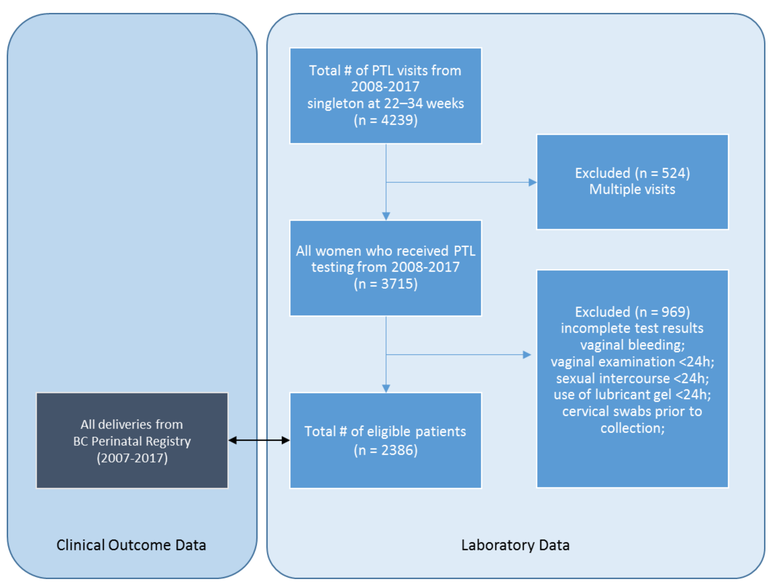


PROBLEM

-The ability to determine the risk of imminent delivery in symptomatic women requires a combination of clinical assessment and biochemical testing, which remains a longstanding diagnostic challenge.
-Recommendations from clinical practice guidelines are inconsistent. No specific algorithms exist at this time.
-fFN is significantly more expensive than Actim Partus (100$ vs 25$).
-Direct comparison of the test performances with adequate sample sizes are currently lacking.
-BC Obstetric Guidelines (Preterm Labour), published in 2005, did not assess clinical utility of Actim Partus.



DATA ANALYSIS



FINDINGS

(n=4347)	Negative Predictive Value (delivery <7 days)	Negative Predictive Value (delivery <14 days)
fFN	99%	97%
Actim Partus	98%	96%
Both tests	99%	97%

PROJECT SPREAD

1. Results dissemination through various educational activities
2. Recommendation will be made to BC Lab Agency UMC to improve test utilization
3. Recommendation will be made to update BC PTL guideline
4. Manuscript will be prepared for publication

CONCLUSION

-Negative predictive values (NPVs) of fFN and Actim Partus has been reported to be >90% and >95% respectively.
-Based on VIHA outcome data, NPVs of these two tests are very high and comparable. A combination of both tests did not offer significant diagnostic advantage, and therefore, it is not cost-effective.
-Actim Partus is significantly less expensive and should be considered as the test of choice in the management of PTL. It can also be offered as a point-of-care test, which would be clinically appropriate in remote communities.
-It is important to note that results generated from this database will need to be externally validated.

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Anesthesia Block Room

Using Parallel Processing to Improve Operating Room Efficiency

PQI PHYSICIAN QUALITY IMPROVEMENT
An SSC Initiative

PROJECT TEAM

Project Lead:
Dr. Gus Chan
Project Participants:
Surgical Informatics team, Island Health
PQI Team
Jason Price, Manager PACU/SDC, RJH
Rachel Wilson, CNE PACU RJH
Heather Irvine, CNL, PACU RJH

AIM STATEMENT

- To improve efficiencies in the Operating Room (OR)and Post Anesthesia Care Unit (PACU)
- To improve quality of analgesia for post-operative pain by using regional anesthesia

PDSA Cycle

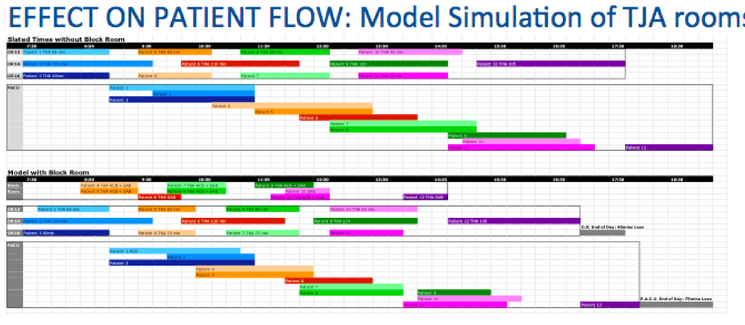
Remodelling
Plan: How can parallel processing provide efficiency?
Do: Collect Data on Anesthesia Controlled Time in OR and spinal resolution time in PACU
Study: Analyze Data
Act: Design model of time usage in OR/PACU with parallel processing in block room

DATA ANALYSIS

- 548 TJA patients Jan-May 2017
- Surgery and Anesthesia time data from Surgical Informatics
- Determined Anesthesia controlled time

- April 2018, 153 patients
- Times for spinal resolution in PACU collected by RNs
- Determined average time to reach discharge criteria

EFFECT ON PATIENT FLOW: Model Simulation of TJA rooms



BACKGROUND

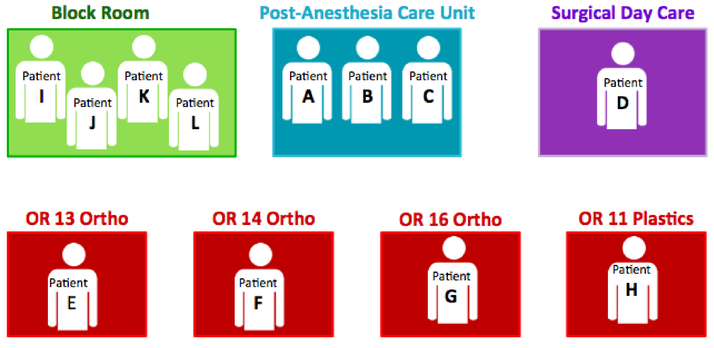
- Excessively long waiting lists for total joint replacement surgery in BC
- Public Health Crisis due to Opioid Use Disorder

PATIENT VOICE

About patient information pamphlets: "This is really helpful information for patients to have and learn about before procedures. It can be scary to have some of the side effects so it's good to know in advance they might happen."



Parallel Processing



PROBLEM

- Insufficient "Surgery Controlled Time"
- Bottleneck in Post Anesthesia Care Unit
- Excessive opioid use for postoperative analgesia

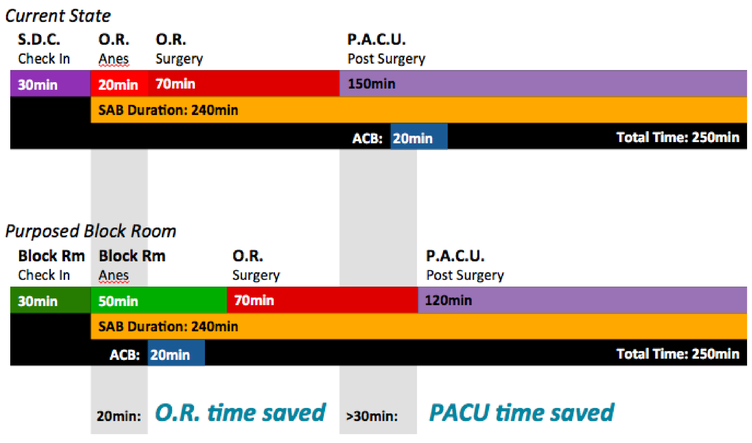
CHANGE IDEA

Implement an *Anesthesia Block Room* where regional anesthesia can be provided using a parallel processing model

PROJECT SPREAD

- Surveys about Pre-Block Safety Checklist within and outside department
- Input from Patient Voice Network
- Discussion with surgical colleagues
- Meetings within Department of Anesthesia
- Meetings with Island Health Surgical Services Working Group

TIME SAVINGS PER CASE: Total Knee Arthroplasty



CONCLUSION

Anesthesia Block Room would save:
- Save 135-180 minutes of OR time per day
- Save 5.5 hours in PACU per day
- Allow 2-3 additional cases per day

Barriers to starting block room include:
- Lack of physician compensation
- Lack of funding for infrastructure
- Resistance to change in culture

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STEP UP for First Episode Psychosis (FEP):
Standardising Treatment of Early Psychosis Utilizing Protocols

PQI PHYSICIAN QUALITY IMPROVEMENT
An SSC Initiative

PROJECT TEAM

Dr. Daniel Boston, Psychiatrist, Early Psychosis Intervention (EPI) Service
Dr. Andrea Bardell, Psychiatrist, EPI Service Lead
Dr. Chris Blashko, Psychiatrist, Inpatient Psychiatric Lead
Dr. Diana Ingram, Psychiatrist, Psychiatric Emergency Services Lead
Dr. Bree Zehm, Mental Health & Substance Use (MHSU) Clinical Pharmacist
Monica Flexhaug, MHSU Project Manager
Susan Rich, MHSU Inpatient Manager
Alison Steinbart, Medication Safety Consultant
Curtis Bilson, PQI Data Analyst
Rosie Holmes, PQI Coordinator
Dr. Daisy Dulay, PQI Physician Advisor

BACKGROUND

Psychotic conditions constitute a major health issue often first occurring in late adolescence. Antipsychotics (APs) are the main pharmacological treatment however polypharmacy is common, not evidence-based and increases the risk of side effects including metabolic abnormalities and weight gain. AP usage necessitates that physical health monitoring that is performed yet this is often inconsistently completed. These factors are partially attributable to people with severe mental illness having a 2-3 times higher mortality rate and a life expectancy 10-20 years less than the general population.

A patient's first episode of psychosis, its treatment, and their experience sets the stage for their future health outcomes and ongoing engagement with the mental health care system. This requires efforts to minimize polypharmacy and to recognize and address side effects.

AIM STATEMENT

This project focussed on admitted patients with first episode psychosis, 17 - 35 years of age, at the Royal Jubilee Hospital in Victoria, BC. Our aim was to achieve a(n): decrease in antipsychotic polypharmacy by 30%, increase baseline monitoring of glucose & lipids to 100%, and to increase baseline & discharge weights to 100% by Sept 30, 2018.

METHODS and PDSAs

This project was supported by both PQI and the South Island Facilities Engagement Initiative. Starting September 1, 2017, we developed an evidence-based clinical order set (COS) for use on hospital admission. Several PDSA cycles were performed: Schizophrenia Spectrum Working Group, Nursing Lead Inpatient Weight Initiative, Bipolar Spectrum and PRN Working Group, Order Set Version 1 and 2. The COS is being trialed from July 1st to September 30th, 2018.

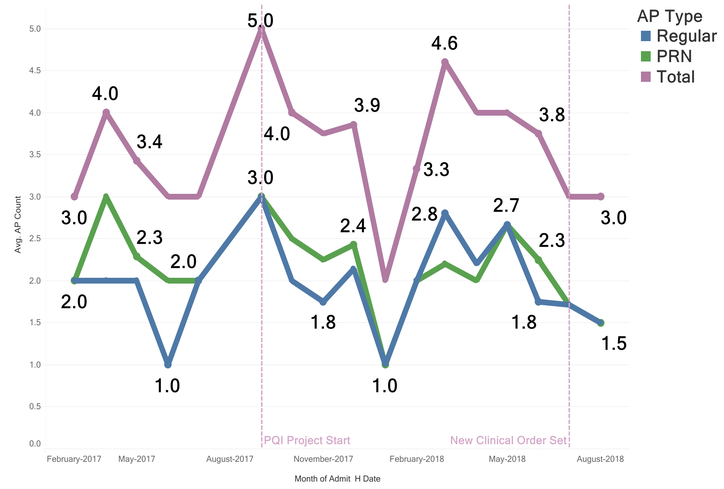
CHANGE IDEAS

- Review relevant Canadian guidelines and provincial EPI standards
- Engage clinical team in improvement
- Engage patients and family in improvement
- Target cultural beliefs around medications of staff
- Develop and implement a clinical order set

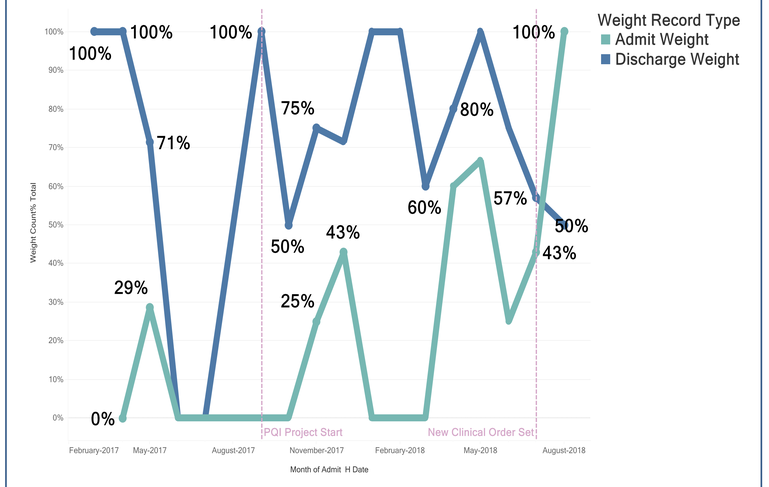
PATIENT VOICE

Patient and parent focus groups were held August 22nd and 23rd, 2018. Patients described their experience with medications as turbulent due to side effects. Parents felt that medications varied by doctor and unit and were switched abruptly without adequate explanation. Concerns regarding physical health issues not being fully addressed were voiced.

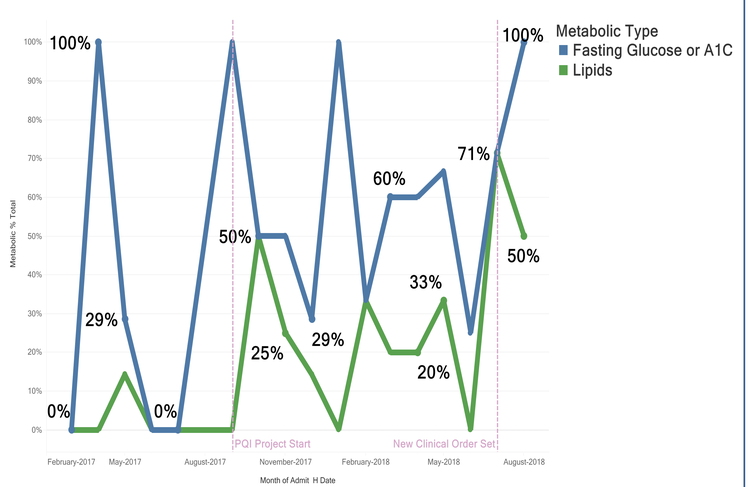
Average Number of Antipsychotics Prescribed per Patient per month



Percent of FEP Patients with weights recorded per month



Percent of FEP Patients with metabolic indicators recorded per month



FINDINGS

Preliminary results from the first two months showed that although 8 patients satisfied the criteria for the project, the COS was only utilized for half of them. Comparing outcomes between patients where the COS was and was not used, there was a 59% decrease in the total number of antipsychotics used (4.25 to 2.5), baseline glucose measured increased from 50 to 100%, baseline lipids measured increased from 25 to 100% and baseline weights measured increased from 50 to 75%. Discharge weight comparisons cannot yet be calculated as not all patients have been discharged.

FUTURE DIRECTIONS

Further PDSA cycles will be required to increase the utilization of the COS and address any concerns. Further engagement with physicians who frequently deviate from guidelines will need to be explored. If improvements are sustained, this project can be adopted permanently and spread to other Island Health sites. It is fully compatible with the future goal of a Computerized Provider Order Entry (CPOE) system. This order set may also be adapted to all admitted psychiatric patients, with EPI patients being one among several distinct modules.

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Special thanks to Dr. Deb Sheinbaum, Dr Wei-Yi Song, Darryl Jackson, Nadine Kot, Michelle Chequer, Chris Nagainis, Marlene Clibberly and many others for additional support and project contributions.

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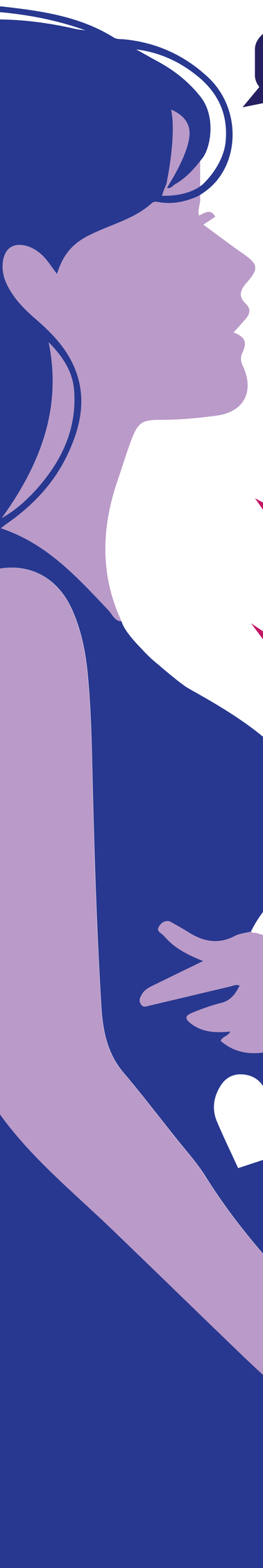
Woman-Centered Care for Early Pregnancy Loss

Patient voices inform a new approach at the Cowichan Maternity Clinic

Miscarriage is more than a medical event,

it is a loss of a dream

PATIENT VOICES



"Miscarriage is a very traumatic experience - it colours the rest of your life"

"I had to wait for a long time in ER and I was separated from my supports.... I knew I wasn't considered a medical emergency but for me it was an emotional emergency"

"My doctor wouldn't see me when I was bleeding"

*"The **Welcome Visit** is a great idea- women can know where to go when they have concerns."*

"I appreciated how the Maternity Clinic got me in to see a doctor and organized an ultrasound for me right away"

"In a bad situation it feels better if you have choices, I liked being offered follow up by phone or in person at the clinic"

BACKGROUND

- **25% of women will experience miscarriage in their lifetime**
- **After a pregnancy loss:**
  - 60% of women experience depression
  - most women report increased anxiety in future pregnancies
- **Threatened miscarriage:**
  - vaginal bleeding +/- cramping in the first 20 wks of pregnancy
  - can be a stressful experience, especially for a woman who has already had a loss
- **Cowichan Maternity Clinic (CMC):**
  - a multidisciplinary team of GPs, MOA, Nurse, Dietician
  - located beside the maternity ward, Cowichan District Hospital
  - provides care for 45% of pregnant women in the Cowichan Valley

PROBLEM

- Women are going to ER for bleeding in pregnancy
- Difficult in ER setting to provide privacy, emotional support, continuity of care for pregnancy loss
- Family doctors/maternity providers lack familiarity with care algorithms
- Common misperception that urgent ultrasounds can only be ordered through ER

AIM STATEMENT

A woman-centered approach to early pregnancy loss (EPL) and early pregnancy bleeding (threatened miscarriage) for patients attached to the Cowichan Maternity Clinic with:

- urgent access to appointments, diagnostic labs and ultrasounds
- unlimited access to follow up visits and phone calls
- emotional support and monitoring for medical complications

will lead to better continuity of care and decreased ER utilization.

We aim to have 90% of women receiving "standard of care" by July 2018.

PDSA Cycle

PLAN: Patient survey drafted, reviewed by patient collaborators

DO: Online/paper versions rolled out

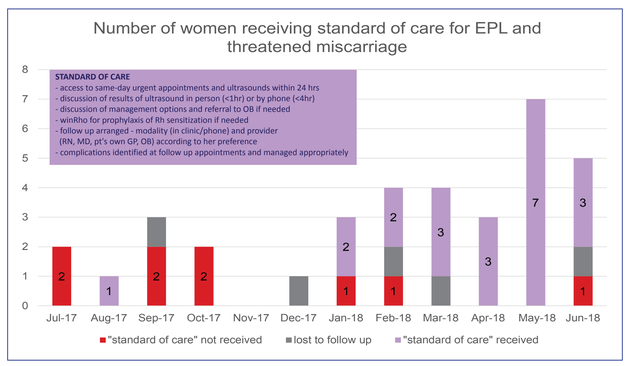
STUDY: Minimal initial surveys completed, most by women in next pregnancy

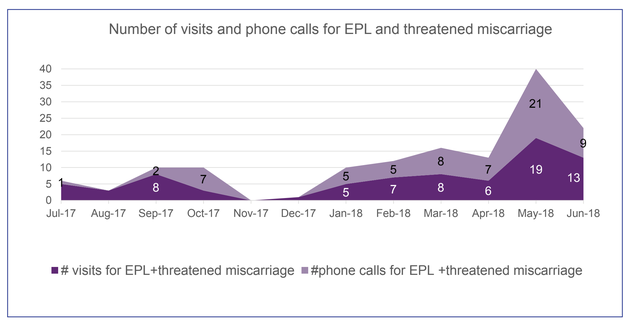
ACT: Gather feedback through focused interviews instead

CHANGE IDEAS



DATA ANALYSIS





FINDINGS

- More women have been seen for early pregnancy loss and threatened miscarriage over time
- There have been more encounters (visits and phone calls) per person over time
- 92% of women received "standard of care" in the last quarter

PROJECT SPREAD

- Spread care algorithm and EMR templates to other maternity providers and GPs in community
- Collaborate with ER to improve transfers in care

CONCLUSION

- Early Pregnancy Loss and threatened miscarriages are emotional emergencies
- Women deserve urgent access to diagnosis and follow up through any care provider they choose to see

PROJECT TEAM

Cowichan Maternity Clinic Team: Dr. Maki Ikemura, Project Lead, Paula Ramwell (RN), Jessica Wilson (MOA), Julie Kostyk (RD)

Patient Voices Collaborators: Alicia Loewen, Robin Kite, Carrie Rae

Cowichan Maternity Clinic Physicians: Dr. Maggie Watt, Dr. Ryan Gallagher, Dr. Kate MacDonald, Dr. Meghan Chabot, Dr. Bridget Henderson, Dr. Donna Wachowich, Dr. Andrea Wilhelm, Dr. Tom Rimmer

Cowichan District Hospital Collaborators: Dr. Yume Kohno (radiology), Dr. Tracey Stephenson (ER), Dr. Luc Beaudet (OB), Dr. Alana Geist (OB), Dr. Fiona Liston (OB), Julia Cianci (RMW), Erin Coates (MSI3), Lindsay Richier (MSI3)

Physician Quality Improvement Coordinators and Advisors: Dr. Sam Kohen, Curtis Bilson, Patricia Muller, Suzanne Beyrodt-Blyt

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For more information on Island Health PQI
Email: PQI@viha.ca
or follow QR Code to website

Graphic Design: Curtis Bilson

PHYSICIAN QUALITY IMPROVEMENT
An SSC Initiative

Capturing Cannabis
Improving Cannabis Disclosure on Hospital Admission

PROJECT TEAM

- Dr. Matthew Moher – *Hospitalist, Project Lead*
- Entire South Island Hospitalist Department
- Dr. John Galbraith – *Medical Microbiologist*
- Dr. Daisy Dulay – *Cardiologist, PQI Physician Advisor*
- Rosanne Holmes – *PQI Coordinator*
- Curtis Bilson – *PQI Data Analyst*

CHANGE IDEA

- Improve capturing cannabis use in 'Social History' of patient record
- Improve documentation of cannabis use, including documentation of non-users
- Improve documentation of dose & formulation
- Culturally acknowledge cannabis use similarities / differences to alcohol or nicotine

PDSA Cycle

- **PDSA 1:** Survey of staff culture associated with patient cannabis use
- **PDSA 2:** Admission History vs Targeted Interviews
- **PDSA 3:** Hospitalist Department Rounds – multiple presentations of project findings
- **PDSA 4:** Continuing Medical Education (CME) engagement – presentation of existing literature on evidence based medical cannabis uses
- **PDSA 5:** ongoing communication with colleagues during project duration



FINDINGS

- Cannabis disclosure was improved during project
- Many cannabis formulations to consider
- Physicians respond to evidence based medicine

BACKGROUND

- In October 2018 Canada is set to become only the third country in the world to legalize recreational cannabis use
- Canada legalized medicinal cannabis years ago, yet it is rarely documented in a patient's medical record
- High proportion of patients use cannabis in one form or another
- Unanswered questions surrounding drug interactions and withdrawal syndromes

"Responsibility is a heavy responsibility"
- Cheech



PROBLEM

Even though more and more patients are using cannabis in it's many forms they don't routinely disclose it. At the same time health care staff are not capturing it patient documentation consistently

PATIENT VOICE

Why didn't they disclose?

- Not asked
- Not perceived as "medicine", more as food
- Stigma – judged by practitioners in past, concerned could affect quality of care
- Legal implications

AIM STATEMENT

Improve cannabis disclosure

- Improve capture of use on admission to Hospitalist service at RJH by 75% in 8 months
- Better understand patient perspective
- Address educational gaps
- Drive sustainability of the improvement

DATA ANALYSIS

Staff Survey: Capturing Cannabis Use

Do you see value in recording cannabis screening to Admission Social History alongside alcohol & cigarette smoking?

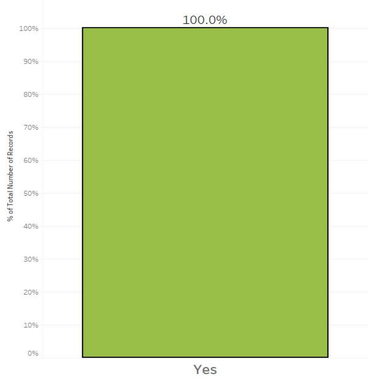


Image 1: *100% of respondents valued cannabis capture.*

Intervention Comparison:
Pre/Post Cannabis Documentation

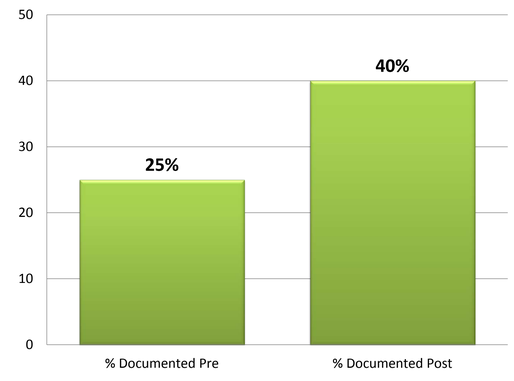


Image 2: *Percent of power chart histories that have cannabis use documented (including non-use indicated), before and after presenting project at Department Rounds*

Intervention Comparison:
Pre/Post Willingness to Prescribe Formulary

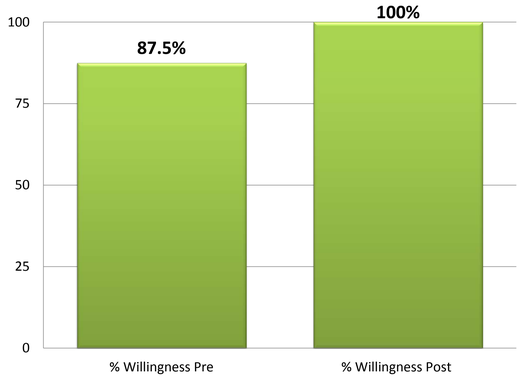


Image 3: *Percent of survey respondents willingness to prescribe hospital formulary cannabis derivative before an after CME on evidence based cannabis medicinal uses*

CONCLUSION

The culture of cannabis use is changing quickly. Medical literature and understanding the health implications surrounding cannabis are evolving rapidly, along with commercial promotion and unfounded claims.
Cannabis is different from alcohol or nicotine in that it's used recreationally as well as being prescribed as a medication.
Our patients need us to listen openly and without judgment.

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The 'P' PROJECT

Quality Improvement for Patients and Staff in the Echocardiography Department



BACKGROUND

- Echocardiograms are completed every 45 minutes in rooms daily from 0700-1800
- There is a level of stress and frustration for echocardiographers when time is lost for an exam as they are required to work on a strict schedule in a fast paced dynamic environment completing comprehensive diagnostic scans of hearts for cardiologists to review and report on
- When patient's arrive late or need to use the washroom during exam time it creates a negative/stressed environment and can compromise exam quality and patient care

PROBLEM

- Average washroom use for an ambulatory patient is 5 minutes
- Patient exam prep is on average 3-4 minutes
- 45 Minute time slots for echocardiograms
- 8-10 minutes are lost per exam if bathroom break is required leaving the Echocardiographer approximately 35 minutes to complete a full diagnostic exam resulting in a lower quality study due to time constraints

PROJECT TEAM



Katie Moore - Echo Supervisor
John He - Echo sonographer

Project Participants:
Dr. Daisy Dulay
Echocardiography Sonographers at the RJH
Echocardiography Lab Clerical Support Staff
Patients

CHANGE IDEA

- Verbal communication from clerical support to tell patients to use the washroom before the scheduled exam when they check in for their appointment
- Appropriate signage
- Initiating a quality improvement project for inpatients using the washroom during their echocardiogram and monitoring while the echocardiography lab shifts to work in the PCC for inpatient exams

AIM STATEMENT

- To have 100% of ambulatory patients use the washroom before their scheduled echocardiogram appointment
- To be completed within 6 months



PDSA I

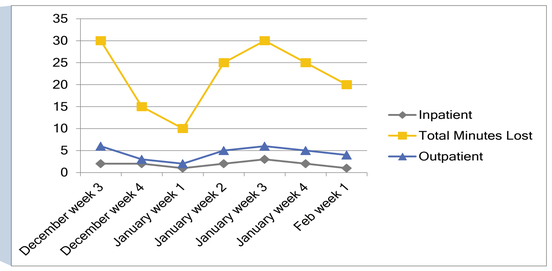
Tally numbers of patients using the washroom.
Set up interview for patient voice.

PDSA II

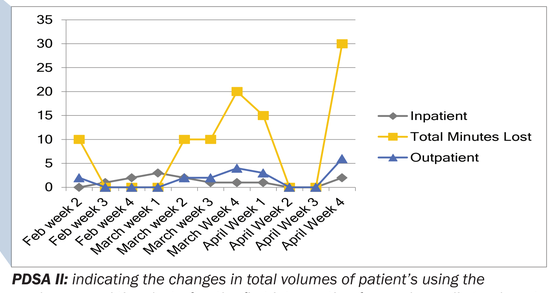
Echocardiographers explained the importance of this project to clerical staff, Clean/Modified signage in waiting room

PDSA III

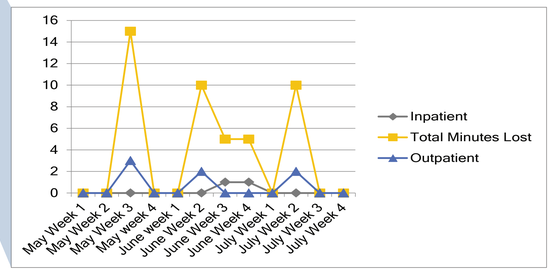
Staff meeting with Clerks, Physicians and echocardiographers explaining findings so far and the importance and impact on patient care



PDSA I: *initial evaluation of the number of patients using the washroom and the total time lost for the week from the exam time*



PDSA II: *indicating the changes in total volumes of patient's using the washroom and time lost after the first intervention from echocardiographers to clerical staff and improving signage.*



PDSA III: *Total improvements in the overall number and time lost after the staff meeting with all parties involved and the patient's voice implemented.*

PATIENT VOICE

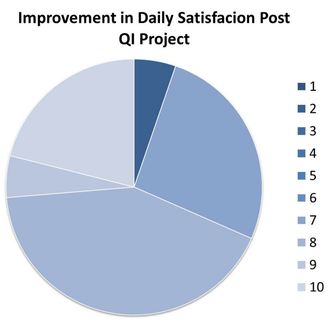
A 2-5 minute survey taken in the procedure room explaining our problem and aim which asked 15 patients about their experience in the waiting room and whether or not they were informed to use the washroom before the exam.

- Was the signage clear?
- Did anyone ask you to use the washroom before the exam?
- What would have made the experience better for you?



PROJECT SPREAD

- Sharing data and outcomes with fellow echocardiography labs
- Submit project poster to PQI Summit and BC Forum



FINDINGS

- Patient voice: a verbal reminder upon checking in is the best way for them to know to use the washroom before their exam time – some thought they had to have a full bladder like a fetal ultrasound
- Signage is often missed but should be kept clear
- When all staff is aware of the issue and are participating there is less time lost in exams improving patient care and exam quality
- ***With this project we have saved 14+ hours of exam time for 2018!!***

CONCLUSION

With teamwork and initiative our ambulatory patients can have a better experience in the echocardiography lab. They have a better understanding of the importance of arriving on time and using the washroom before the echocardiogram and have helped improve the flow and day for the echocardiographers. As a team we have seen dramatic increases in day to day work satisfaction through an engagement survey which directly leads to improved patient experience and a higher incidence of comprehensive diagnostic echocardiograms. Future steps will include investigating the inpatient's washroom use in our lab as their average time to use the washroom is 10 minutes.

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NUDGING to LOWER WAIT TIMES

Modifying Physician ECHO Ordering Behaviors through Positive Encouragement

PROJECT TEAM

Dr. Daisy Dulay - Project Lead

Echocardiology:
- Sara Quist - *Clerical*
- Kim Ostrinski - *Project Analyst*
- Claire Mackelson - *QA Supervisor*
- Katie Moore - *Current Echo Supervisor*
- Amanda Deforge - *Echo Manager*
- Alissa Merz - *Senior Business Analyst*
- Ryan Davis - *Heart Health Director*

Physician Quality Improvement:
- Rosie Holmes - *PQI Coordinator*
- Curtis Bilson - *Data Analyst*

BACKGROUND

Island Health echo wait times exceed recommended times in Canada

- Unable to expand due to physical space limitations, operational costs, and staff shortages
- 30% of US healthcare spending does not improve patient health
- Feedback to referring physicians has been shown to reduce unnecessary echos [Berwick et al, JAMA 2013; Bhatia et al, JACC 2017]

PROBLEM

- Although wait times have been improving, due to staffing shortages:
- **Up until May 2017:**
  Mean and median wait times are 200 days
- **April 2017 to Jan 2018:**
  Mean 143 days and median 82 days

Urgency Category	Recommended Wait Times
Emergent	Within 1 day
Urgent/Semi-urgent	Within 7 days
Scheduled	Within 30 days

AIM of PROJECT

To reduce wait time by 5% through:
- Identifying largest ordering MD group
- Showing data and reviewing appropriate use criteria (AUC) to that group

PATIENT IMPACT

Inappropriate studies affect care:
- Delays in diagnosis and management for patients waiting
- Inconvenience factor for patients who undergo unnecessary testing

Development of *AUC* and *Choose Wisely* campaigns are aimed at reducing unnecessary testing

Choosing Wisely Canada™

ASE Foundation AUC for Echocardiography

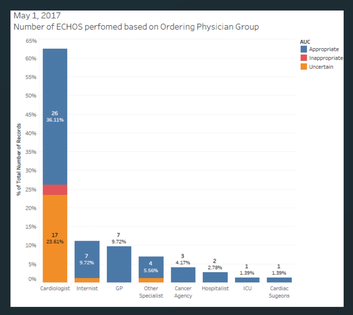
METHODOLOGY

- All May 1st 2017 RJH echos analyzed based on clinical indication, level of urgency, referring group and AUC
- Spoke to Cardiologists of preliminary data (1st Nudge) Dec 2017
- Randomly picked 10 studies from each cardiologists for AUC based on age, meeting attendance
- Survey given to cardiologists regarding AUC
- Follow-up presentation and second nudge May 2018

PDSA Cycles

PDSA 1 May 2017: Determining the largest ordering MD group
PDSA 2 Dec 2017: Talk given to Cardiologists about AUC & preliminary data
PDSA 3: Poll Survey
PDSA 4: Follow-up talk May 2018 & results
Pending: Updated wait time results

PDSA #1

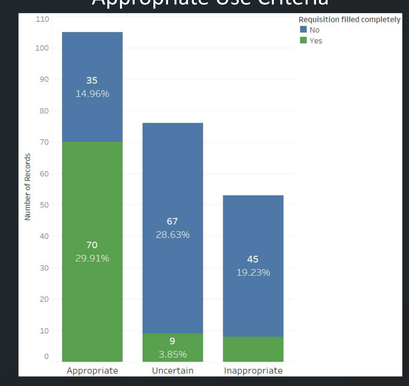


One day snapshot: RJH echos May 1st, 2017
- Largest ordering group: ***Cardiologist***
- Up to 25% of echo ordered by the cardiologist group were inappropriate or uncertain (usually not enough info on the requisition)
- 75% requisitions were incompletely filled
- Higher than Halifax study: 10% inappropriate & 10% uncertain*;

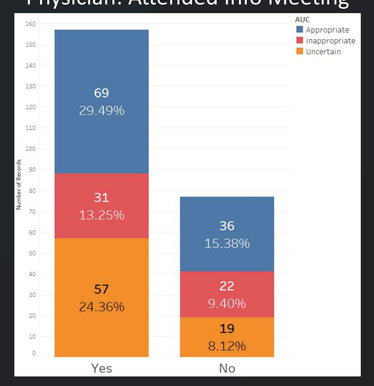
*caveat: one day analysis versus one month

PDSA #2

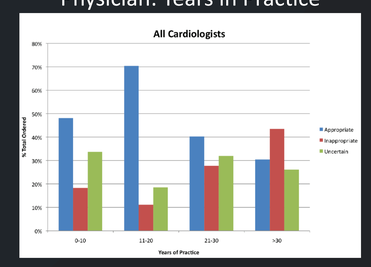
Appropriate Use Criteria



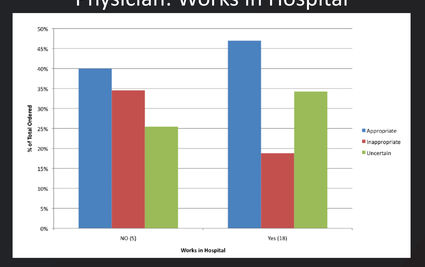
Physician: Attended Info Meeting



Physician: Years in Practice

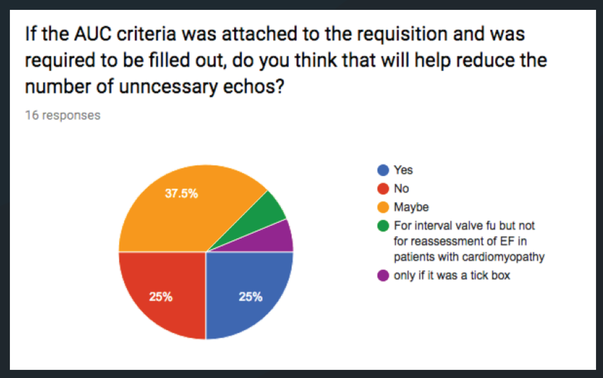


Physician: Works in Hospital



PDSA #3

- Survey results 17/22 cardiologists responded
- 2/3 attended the December meeting
- Majority have not, but do plan to download the AUC app
- Most were receptive with adding AUC as part of the requisition but also wanted to revamp the requisition to be more useful
- Only a 25% feel that adding AUC criteria may help reduce the number of unnecessary echos



PROJECT SPREAD

- Ongoing feedback requires knowledgeable staff to review echo requests to determine appropriateness
- Transition between previous and new supervisor may cause project challenges
- Could be applicable to other problems in echo lab (perioperative echo and stress echo)
- Could be applicable to cardiac lab for their wait times

FINDINGS

- Wait times are improving due to increased staffing
- Difficult yet to determine the impact of nudging in reducing wait times
- Mid career cardiologist tend to order echos more appropriate compared to early or late career cardiologists
- Feedback indicated that the echo requisition needs revamping and adding AUC may potentially be helpful as a reminder
- Changing behavior takes time and feedback

WHAT'S NEXT?

DO: Get update on the wait times from Jan 2018 onward
STUDY: Provide feedback to top three users and 3-4 other cardiologists every 3 months via email.
ACT: Set up a CME like rounds regarding echo recommendations for valvular surveillance for the cardiologist.

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Graphic Design: Curtis Bilson

Implementing Surgical Early Pregnancy Loss Management In The Emergency Department.

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PROJECT TEAM

Regina Renner MD, MPH, FRCSC, FACOG (Obstetrics & Gynaecology), Project Lead

Emergency Department:
Greg Culp (Medical Lead ED)
Kevin McMeel (Lead Proceduralist Services)
Lisa McLeod (Nurse Manager ED)
Karen Ibbotson (Nurse Champion)
Mark Hunns (Nurse Educator ED)

PQI Team:
Sam Kohen
Curtis Bilson
Patricia Muller
Suzanne Beyrodt-Blyt

OB&GYN (surgeons):
Jennifer Lajoie
Kristi Kyle
Luz Arbelaez
Evelyn Eng
Gbenga Oluyede
Jeff Somerville

PACU: Barb Wall (Clinical Nurse Leader)
MDRD: Sheena McKay (Manager)

AIM STATEMENT

Primary Aim:

Decrease the time from Emergency Department (ED) presentation for EPL to discharge after a uterine aspiration from 26hr (Oct 2016-Apr 2017) to less than 5hr by July 2018

Secondary Aims:

- Decrease wait time from OR booking to OR start time
- Improve patient and provider satisfaction
- Decrease cost

PDSA Cycle

Small Test of Change

- Retrospective data collection
- Survey development
- Supply cart for ED
- Staff education
- Implementation with prospective data collection
- Discharge instructions

PROJECT SPREAD

- Due to lack of availability of ED, proceduralist resources, especially nurses the project has been halted for the time being.
- Reassessment for potential new start planned in September 2018

BACKGROUND

- At NRGH 80 women per year undergo a uterine aspiration for ***early pregnancy loss*** (EPL)
- These are scheduled on the emergency slate

PATIENT VOICE

"The wait time and not knowing when the procedure was going to happen was extremely difficult and I felt very alone"
- patient (who had a procedure in the OR)



Detroit Institute of Arts

"I was happy with my choice of a D&C in the ED and would do it again!"
- patient (who had a procedure in the OR)

PROBLEM

- Lack of timely access to surgical management of EPL in the operating room
- Long emergency operating room wait list
- Wait time, multiple visits and uncertainty about timing is an emotional and logistical burden for women
- Wait time might take up extra resources & costs of hospital

CHANGE IDEA

Offer women with an EPL up to 12+6weeks gestation:

- uterine aspiration with local anaesthesia (provided by gynaecologist)
- under IV sedation (provided by the proceduralist) in the ED

DATA ANALYSIS

Outcome measures

- Process efficiency: times from ED presentation until postop discharge
- Satisfaction / Experience of patients

Process measures

- Wait time from OR booking to entering OR
- Wait time from procedure end to discharge
- Number of women undergoing uterine aspiration in ED vs OR
- Staff satisfaction and experience
- Cost

Balancing measures

- Complications, ED resources

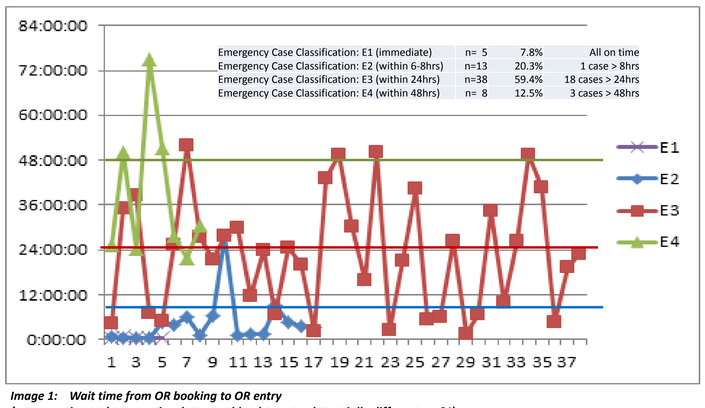


Image 1: Wait time from OR booking to OR entry (retrospective and prospective data; combined as not substantially different; n=64)

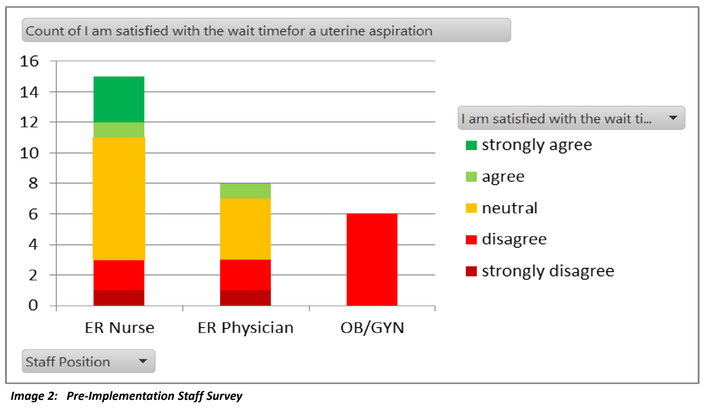
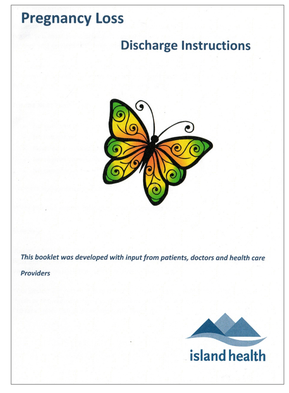


Image 2: Pre-Implementation Staff Survey



FINDINGS

- Almost 50% of E3 and E4 procedures exceed their set time limit
- 95% women are satisfied with the overall service, but only 64% are with wait times
- Physicians are especially not satisfied with the wait time
- One procedure done in the ED (2hr wait time); patient satisfied; review with staff identifies need for more education on gynecology procedures
- At least 5 other procedures declined by the ED due to staff and resource shortage
- Prelim cost analysis showed ED procedure to be significantly less expensive than OR procedure (210,- vs 2014,- CAD)

CONCLUSION

- Women and physicians are dissatisfied with the long wait time for a uterine aspiration procedure for early pregnancy loss.
- Almost 50% of E3 and E4 procedures are not completed within their time goals
- Implementing the procedure in the ED requires more staff resources and education to increase comfort and ease for staff.

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"Let's Talk About What Matters Most."

SERIOUS ILLNESS CONVERSATIONS in HEMODIALYSIS CARE

PROJECT TEAM



From L-R in photo receiving *Island Health Award:*
Dr. Gaylene Hargrove - Nephrolology
Monica O'Donnell - Social Worker
Maureen Glass - Dialysis RN
Dan Martinusen - Renal Pharmacist
Dr. Christine Jones - Palliative Care, Project Lead
Linne - Hemodialysis Patient Advisor
Helena Daudt - Victoria Hospice Research & Education
Taylor Matson - Co-op student Research & Education
Team members not in photo:
Dylan Gadd - Clinical Nurse Educator
Maureen Conly - Nurse
Julia Caryk - Clinical Nurse Educator
Janet Bauer - Patient Voice

BACKGROUND

Patient's in the final year of life tend to receive aggressive medical care, not always consistent with their wishes. High quality patient centred conversations have been shown to improve patient and family satisfaction with care, and reduce burdensome interventions.
Island Health has endorsed the use of the *Serious Illness Conversations Guide*, which this project aims to implement

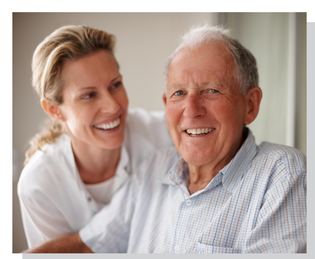
PATIENT VOICE

"These conversations are important. I know I'm going to die... I like the idea of knowing what lies ahead"

Linnie,
dialysis patient

PROBLEM

Multidisciplinary staff are well placed to have *Serious Illness Conversations* but do not feel empowered, are fearful of destroying patient hope and require support to implement "in the moment" conversations into day to day practice.



AIM STATEMENT

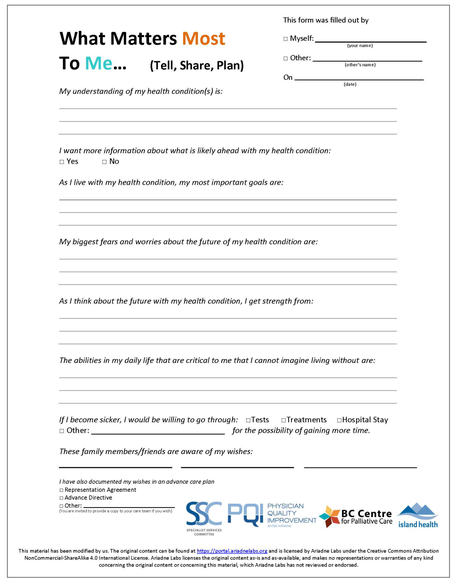
This project aimed to improve the experience with *serious illness conversations* for patients on the RJH hemodialysis unit by 50% over a 6 month period.

PDSA Cycles

PDSA 1 - Focus Groups:
Qualitative data on current practices, barriers and opportunities
PDSA 2 - Environmental Scan:
On goals of care documentation
PDSA 3 - Staff Surveys
Confidence in End-of-Life skills
PDSA 4: Patient Experience Surveys
Patient centered perspective on End-of-Life conversations

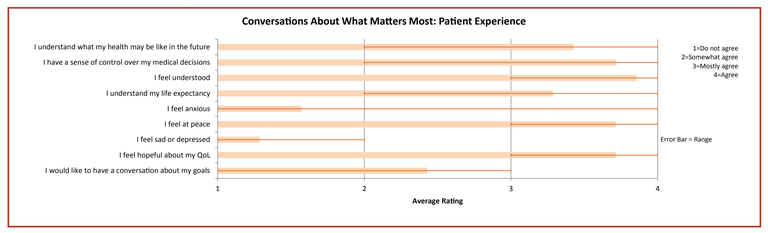
TOOLS



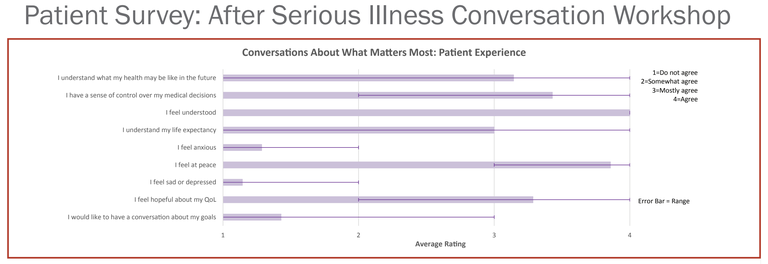


DATA ANALYSIS

Patient Survey: Prior to Serious Illness Conversation Workshop



Patient Survey: After Serious Illness Conversation Workshop



FINDINGS

- Staff survey reveals staff feel confident in conversations, yet focus groups identified multiple barriers to implementation
- Stable hemodialysis patients are not distressed about their quality of life and express a wish to have conversations about the future
- Environmental Scan reveals little goals of care documentation beyond the MOST status

NEXT STEPS

Based on Staff and Patient Feedback

1. Private Spaces for Intimate Conversations
2. Simulated Education for staff
3. Debriefing for staff on:
- Difficult conversations
- Caring for dying patients
4. Structured Documentation Processes

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MAiD REFERRAL ENHANCEMENT

Improving the Processes in Medical Assistance in Dying

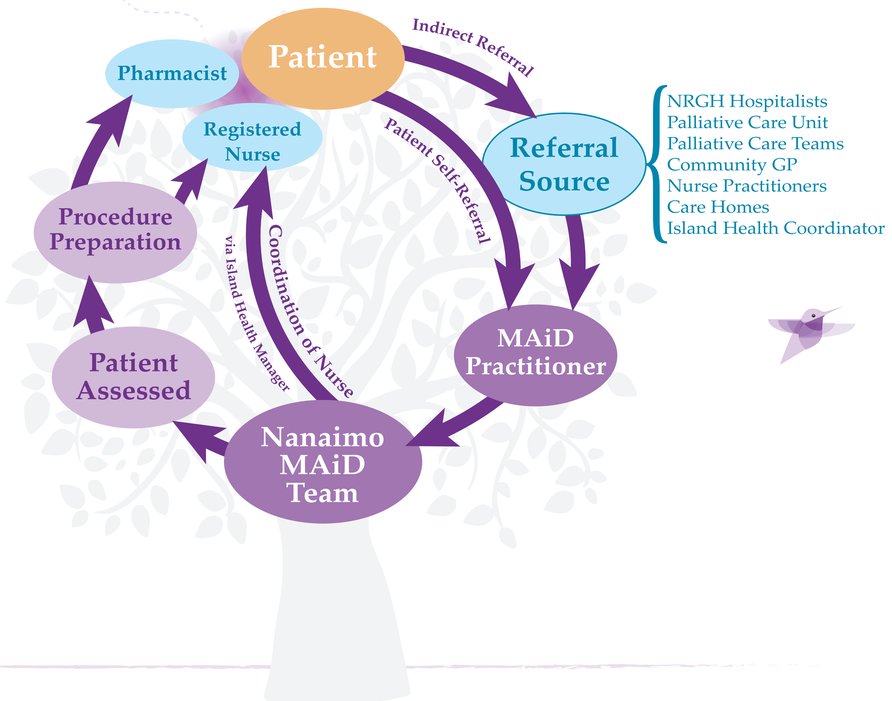
PROJECT TEAM

- **Dr. Diane Wallis -** MD CCFP, Project Lead
- **Janet Bauer -** Patient Voice
- **Helia Sillem -** Manager, NRGH Palliative Care Unit
- **Lise Dawson -** Nurse Practitioner
- **Erica Holling -** Nurse Practitioner
- **Rosanne Beuthin -** MAiD Coordinator, Island Health
- **PQI Technical Team**

CHANGE IDEA

- Patient presentation with completed forms used as a marker of knowledge
- Provide accessible local information to improve the referral process for patients

Nanaimo MAiD Patient Referral Pathway



BACKGROUND

- Legislation governing Medical Assistance in Dying (MAID) was passed by Canadian Federal Parliament June 17, 2016
- Physician lead has been a Nanaimo MAID prescriber since May 2017
- Noted poor coordination between local providers
- Recognized high proportion of patients assessed with no prior paperwork completed
- Listened to patients describe their struggle To get MAID

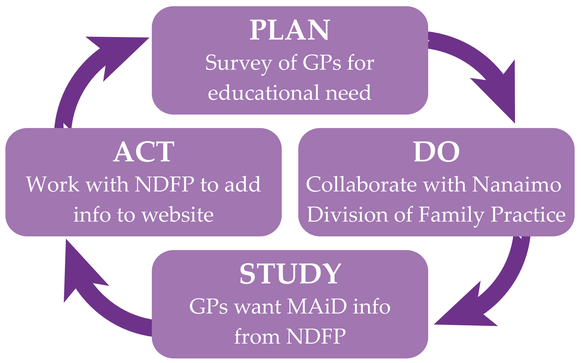
PATIENT VOICE

"it has taken me 6 months to get to see you for this assessment"

Nanaimo ASSISTED DYiNG

Logo design for project communication materials

SURVEY DESIGN



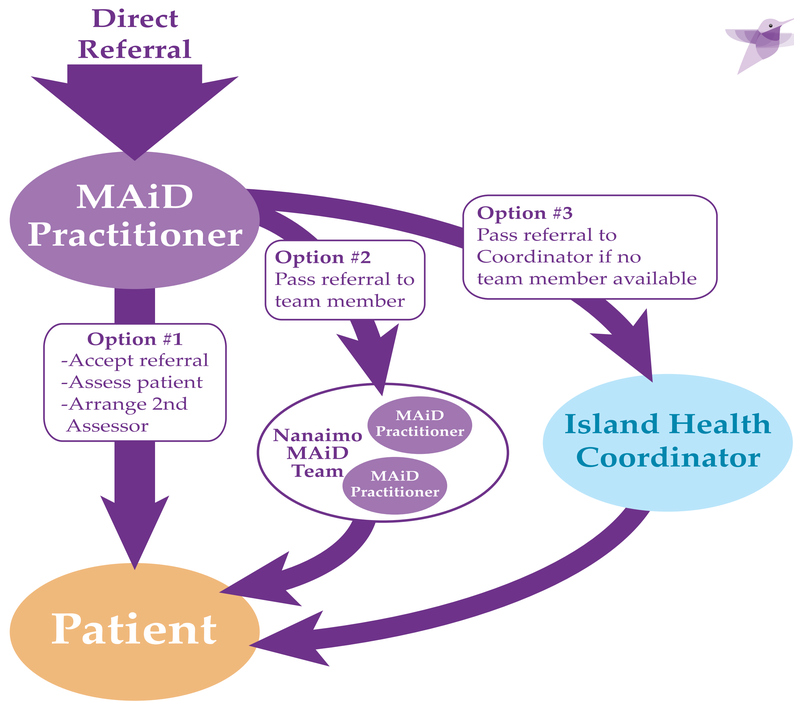
PROBLEM

- Isolation of MAID practitioners risks burnout
- Lack of coordination increases difficulty of arranging assessments for patients
- Lack of paperwork implies lack of knowledge and information for public and physicians

AIM STATEMENT

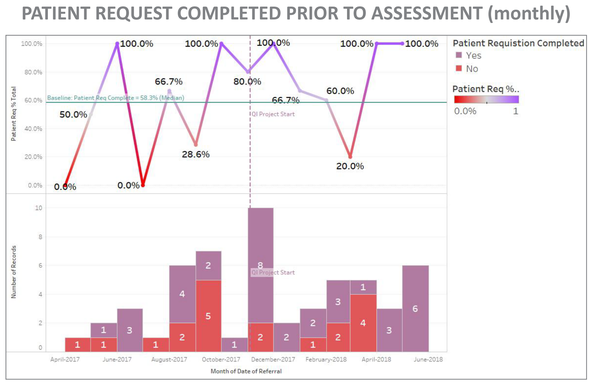
- To develop a clear process for referral of patients requesting MAID, easily accessed by GPs and patients in Nanaimo.
- Information to be accessible to physicians and public.
- To Increase the percentage of patients seen for assessment with correctly completed request form to 80% by September 2018.

Nanaimo MAiD Team Internal Referral Process

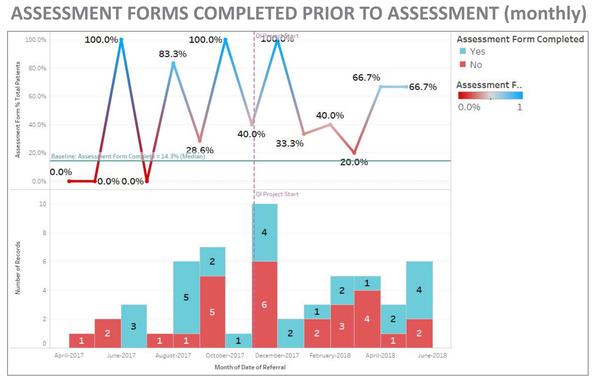


DATA ANALYSIS

PATIENT REQUEST COMPLETED PRIOR TO ASSESSMENT (monthly)



ASSESSMENT FORMS COMPLETED PRIOR TO ASSESSMENT (monthly)



PROJECT SPREAD

- Local MAID provider team now in place and communicating
- One additional prescriber joined local team
- Three independent witnesses recruited for Nanaimo
- Presentations to GPs and public
- Encouraging support from local hospice
- Ongoing collaboration & education efforts in local physician community
- Development of information sheet for physicians
- Development of website for physicians and public

FINDINGS

- Local providers now able to share and discuss cases, improving patient access to MAID
- Increased percentage of completed patient request forms at assessment to over 80%
- Percentage of patients having assessment form GP relatively static

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or follow QR Code to website

CONCLUSION

The local MAID practitioners are now in regular communication with each other and have decided how best to manage referrals for MAID assessment or provision. By working with Island Health and the NDFP there is opportunity to build on the project and disseminate information to physicians and patients. There is a need to continue to encourage new MAID practitioners to join the existing team and add sustainability to the local service. Three independent witnesses have been recruited and have completed training to support patients by witnessing their requests. Development of a local information sheet for physicians and a website which can be linked to Island Health and Nanaimo Division of Family Practice resources will be an asset for the public and professionals alike.

Graphic Design: Curtis Bilson

Psychotherapy Prescriptions for Mental Health

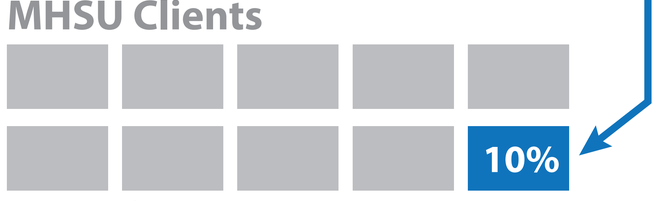
Encouraging Clients to Access Mental Health Services

BACKGROUND

Mental Health and Substance Use (MHSU)
Access and Crisis Response Services is the central intake point for Greater Victoria.
Clients referred to MHSU are thoroughly assessed by mental health clinicians.
Mental Health clinicians process nearly 1,000 referrals each month.
Many of these individuals would benefit from the wide range of community programs available.

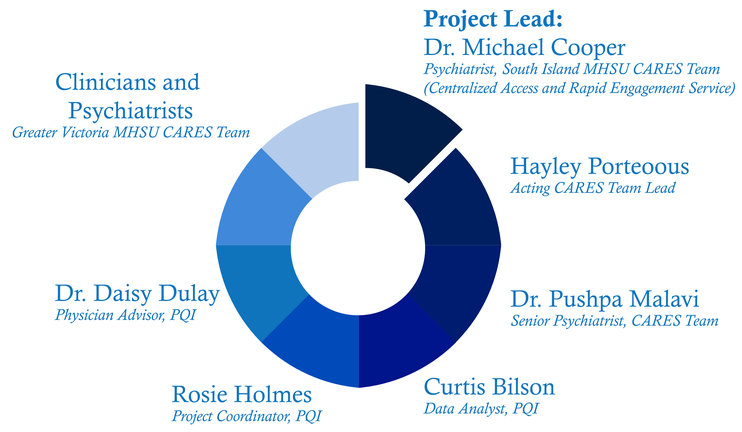
PROBLEM

Clients are given a list of community programs that might be helpful.
However only about **10% of clients follow up.**



only 10% follow up on community programs

PROJECT TEAM



CHANGE IDEA

There is good evidence that an "exercise prescription" improves the likelihood of clients taking steps to improve their physical health. A psychotherapy prescription might help in a similar way to address mental health.
This project assessed whether uptake of recommendations for mental health programs would be improved by using a "prescription" for psychotherapy.



OPPORTUNITIES for IMPROVEMENT

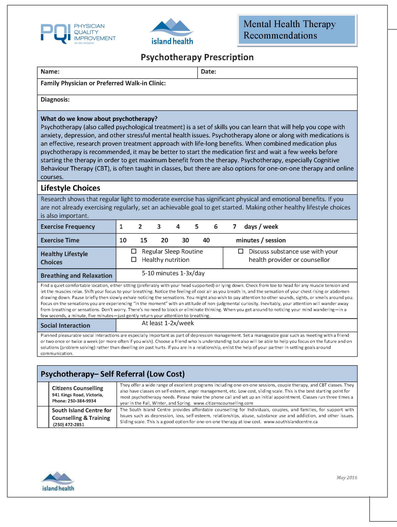
- Overcoming stigma and resistance
- Providing helpful lifestyle strategies that have good evidence
- Provide details of community and online resources

DATA ANALYSIS

Baseline Review of MH Intake Team Psychiatrists:

- Conducted Jan - Feb 2018
- 52 patients reviewed
- Average wait time for a psychiatrist consult was 82 days
- Many wait 3-4 months, up to 6 months
- 44% of clients had refractory disorders
- 85% of clients had full service GPs
- Most clients had seen a clinician prior to the psychiatric consultation
- Clinicians provided appropriate and detailed recommendations for community based programs

PSYCHOTHERAPY RECOMMENDATIONS



PQI PHYSICIAN QUALITY IMPROVEMENT An SSC Initiative — island health — Mental Health Therapy Recommendations

Psychotherapy Prescription

Name:	Date:
Family Physician or Preferred Walk-in Clinic:	
Diagnosis:	

What do we know about psychotherapy?
Psychotherapy (also called psychological treatment) is a set of skills you can learn that will help you cope with anxiety, depression, and other stressful mental health issues. Psychotherapy alone or along with medications is an effective, research proven treatment approach with life-long benefits. When combined medication plus psychotherapy is recommended, it may be better to start the medication first and wait a few weeks before starting the therapy in order to get maximum benefit from the therapy. Psychotherapy, especially Cognitive Behaviour Therapy (CBT), is often taught in classes, but there are also options for one-on-one therapy and online courses.

Lifestyle Choices

Research shows that regular light to moderate exercise has significant physical and emotional benefits. If you are not already exercising regularly, set an achievable goal to get started. Making other healthy lifestyle choices is also important.

Exercise Frequency	1 2 3 4 5 6 7	days / week
Exercise Time	10 15 20 30 40	minutes / session
Healthy Lifestyle Choices	☐ Regular Sleep Routine ☐ Healthy nutrition	☐ Discuss substance use with your health provider or counsellor
Breathing and Relaxation	5-10 minutes 1-3x/day	

Find a quiet comfortable location, either sitting (preferably with your head supported) or lying down. Check from toe to head for any muscle tension and let the muscles relax. Shift your focus to your breathing. Notice the feeling of cool air as you breath in, and the sensation of your chest rising or abdomen drawing down. Pause briefly then slowly exhale noticing the sensations. You might also wish to pay attention to other sounds, sights, or smells around you. Focus on the sensations you are experiencing "in the moment" with an attitude of non-judgmental curiosity. Inevitably, your attention will wander away from your breathing to other things. Don't worry. That's normal. Gently redirect it back to breathing. When you get around to noticing your mind wandering—in a few seconds, a minute, five minutes—just gently refocus attention to breathing.

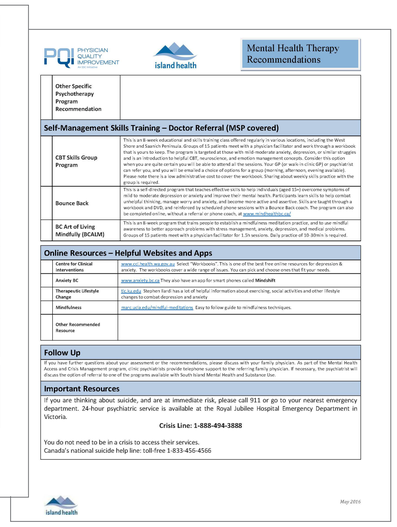
Social Interaction	At least 1-2x/week

Planned pleasurable social interactions are especially important as part of depression management. Set a manageable goal such as meeting with a friend or two once or twice a week (or more often if you wish). Choose a friend who is understanding but also will be able to help you focus on the future and on solutions (problem solving) rather than dwelling on past hurts. If you are in a relationship, enlist the help of your partner in setting goals around communication.

Psychotherapy– Self Referral (Low Cost)

Citizens Counselling 941 Kings Road, Victoria, Phone: 250-384-6914	They offer a wide range of excellent programs including one-on-one sessions, couple therapy, and CBT classes. They also have classes on self esteem, anger management, etc. Low cost, sliding scale. This is the best starting point for most psychotherapy needs. Please make the phone call and set up an initial appointment. Classes run three times a year in the Fall, Winter, and Spring. www.citizenscounselling.com
South Island Centre for Counselling & Training (250) 472-2811	The South Island Centre provides affordable counseling for individuals, couples, and families, for support with issues such as depression, loss, self-esteem, relationships, abuse, substance use and addiction, and other issues. Sliding scale. This is a good option for one-on-one therapy at low cost. www.southislandcentre.ca

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Other Specific Psychotherapy Program Recommendation	

Self-Management Skills Training – Doctor Referral (MSP covered)

CBT Skills Group Program	This is an 8 week educational and skills training class offered regularly in various locations, including the West Shore and Saanich Peninsula. Groups of 15 patients meet with a physician facilitator and work through a workbook that is yours to keep. The program is targeted at those with mild-moderate anxiety, depression, or similar struggles and is an introduction to helpful CBT, neuroscience, and emotion management concepts. Consider this option when you are quite certain you will be able to attend all the sessions. Your GP (or work-in clinic GP) or psychiatrist can refer you, and you will be emailed a choice of locations for a group (morning, afternoon, evening available). Please note that it is the administrative unit to cover the workbook. Sharing about anxiety skills practice with this group is required.
Bounce Back	This is a self-directed program that teaches effective skills to help individuals (aged 15+) overcome symptoms of mild to moderate depression or anxiety and improve their mental health. Participants learn skills to help combat unhelpful thinking, manage worry and anxiety, and become more active and assertive. Skills are taught through a workbook and DVD, and reinforced by scheduled phone sessions with a Bounce Back coach. The program can also be completed online, without a referral or phone coach, at www.mindhealthy.ca/
BC Art of Living Mindfully (BCALM)	This is an 8 week program that trains people to establish a mindfulness meditation practice, and to use mindful awareness to better approach problems with stress management, anxiety, depression, and medical problems. Groups of 15 patients meet with a physician facilitator for 1.5h sessions. Daily practice of 10-30min is required.

Online Resources – Helpful Websites and Apps

Centre for Clinical Interventions	www.cci.health.wa.gov.au Select "Workbooks". This is one of the best free online resources for depression & anxiety. The workbooks cover a wide range of issues. You can pick and choose ones that fit your needs.
Anxiety BC	www.anxietybc.ca They also have an app for smart phones called **MindShift**
Therapeutic Lifestyle Change	bc.tls.ca/ Stephen Ilardi has a lot of 'helpful' information about exercising, social activities and other lifestyle changes to combat depression and anxiety.
Mindfulness	www.ucla.edu/mindful-meditations Easy to follow guide to mindfulness techniques.
Other Recommended Resource	

Follow Up

If you have further questions about your assessment or the recommendations, please discuss with your family physician. As part of the Mental Health Access and Crisis Management program, clinic psychiatrists provide telephone support to the referring family physician. If necessary, the psychiatrist will discuss the option of referral to one of the programs available with South Island Mental Health and Substance Use.

Important Resources

If you are thinking about suicide, and are at immediate risk, please call 911 or go to your nearest emergency department. 24-hour psychiatric service is available at the Royal Jubilee Hospital Emergency Department in Victoria.

Crisis Line: 1-888-494-3888

You do not need to be in a crisis to access their services.
Canada's national suicide help line: toll-free 1-833-456-4566

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PROJECT SPREAD

- Use of information poster to communicate findings of baseline survey to colleagues
- Distribute modified *Mental Health Therapy* forms to clinicians ("Psychotherapy Recommendations" instead of prescription)
- Clinician survey regarding use of MH prescriptions
- Online client survey regarding access to MH services
- Present project findings at conferences
- Distribute information to family practitioners
- Adapt for different communities or special populations

CONCLUSION

The need for mental health services far exceeds available resources.
Making full use of community-based programs and online resources may help clients to access appropriate therapy sooner.
There are many complex factors that make accessing mental health treatment challenging.
The psychotherapy prescription should be a helpful tool to address some of these issues.

SSC SPECIALIST SERVICES COMMITTEE

island health

PQI PHYSICIAN QUALITY IMPROVEMENT An SSC Initiative

For more information on Island Health PQI
Email: PQI@viha.ca
or follow QR Code to website

Graphic Design: Curtis Bilson