Improving Continuity of Care for Ophthalmology Patients

Dr. Adrienne Duimering, Dr. Jonathan Heston, Rachel Unruh, Jessica Barber, Taylor Delraye, Dr. Hamza Khan,
Muneeza Rufi, Niloufar Shakerian, Darien Peacock

AIM STATEMENT

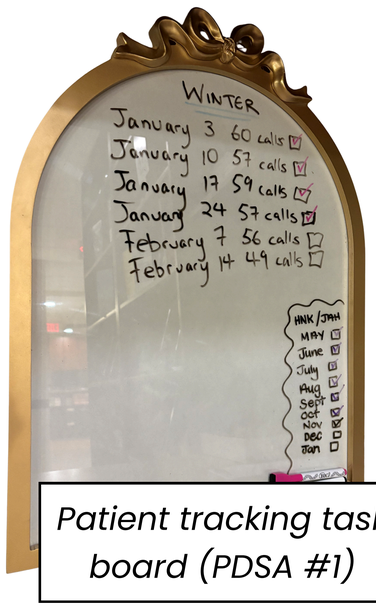
In our Victoria-based community ophthalmology practice, we aim to achieve and maintain a 95% retention rate among patients requiring long-term follow-up by March 31, 2026

RATIONALE

- In a general ophthalmology clinic, many patients require **long-term follow-up care** for common conditions (glaucoma, macular degeneration, and diabetic retinopathy)
- Patients **lost to follow-up** may present later with progressive disease, requiring **intensive treatment** and resulting in a **poorer prognosis**
- Follow-up booking processes at our community ophthalmology clinic were **inefficient**, causing **long wait times**, **high no-show rates**, **frequent rescheduling** and **delayed access to care**
- Subsequent recall and online booking strategies failed to reliably engage patients, overwhelming clinic phone capacity and leaving up to **two-thirds of patients being lost to follow-up**



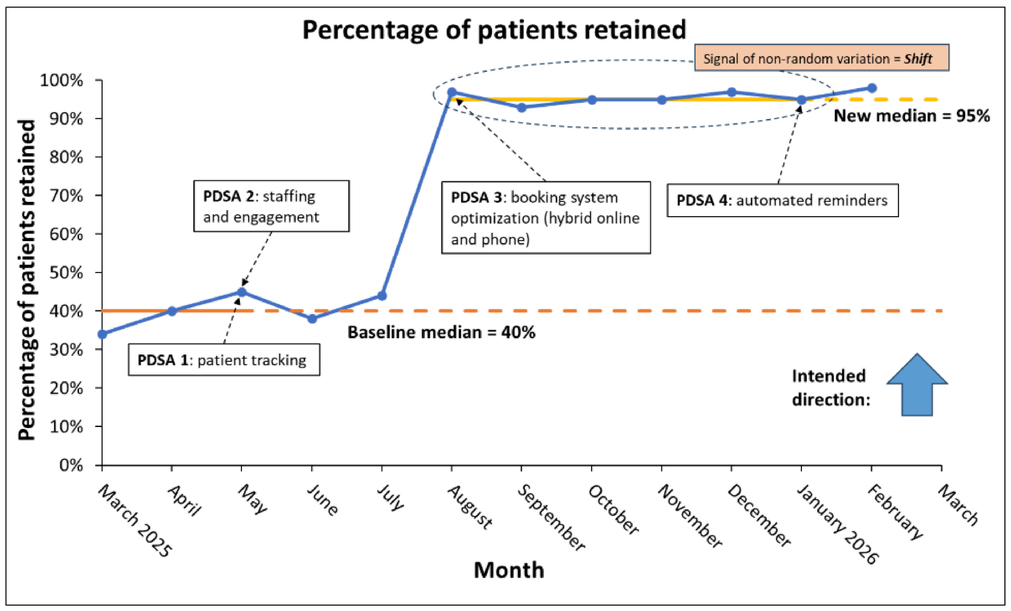
Patients provided feedback using an **online booking form** and **3-point smile scale** iPad located in the waiting room



Patient tracking task board (PDSA #1)

ACTION TAKEN

- **PDSA #1:** Patient tracking task board for lost to follow-up patients
- **PDSA #2:** Staffing and engagement (morning huddles, external consultant, equal distribution of phone call workload)
- **PDSA #3:** Booking system optimization (hybrid online and phone)
- **PDSA #4:** Automated patient reminders



MEASURES

Outcome Measure:

- Percentage (%) of patients retained each month

Process Measures:

- Percentage (%) of patients booking online
- Equal distribution of phone calls between all staff members

Balancing Measures:

- Staff satisfaction
- Patient satisfaction

LESSONS LEARNED

- Technology alone cannot drive change
- Scalability and sustainability requires staff capacity planning
- Online booking invitations generated unintended phone call volume

NEXT STEPS

- Booking at point of care with patient-led rescheduling
- Remote staff to increase phone line capacity
- Reducing oversight to build staff-led sustainability

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Perioperative Anxiety in Children

Dr. Alison Tedder (Physician Lead), Dr. Greg Allen (Project Participant), Dr. Nicole Quigley (Project Participant) , Dr. Blair Goranson (Project Participant), Carrie Tuck (Executive Sponsor), Dr. Bryan Wong (Operational Sponsor), Marie Vaartstra (Patient Partner) and Valerie Swanston (Medical Student)

AIM

By June 2026, reduce reported anxiety by 50% in paediatric dental surgery population in Saanich Peninsula Hospital

RATIONALE

- Pediatric dental surgery is often the first encounter with the medical system and operating room
- Health care induced stress predisposes kids to generalized anxiety and major depressive disorders in adulthood
- Risk factors include: younger age, parental anxiety, previous negative experience and longer procedure duration
- Saanich Peninsula Hospital's team did not have a method to identify anxiety or treat it in a consistent and patient-centered way.
- Perioperative anxiety has multiple effects, including: increased staff distress, delayed discharge due to delirium and poor patient experiences and outcomes

ACTIONS

- **PDSA #1:** Involve anaesthesiologists in periopartive screening directly before surgery
- **PDSA #2:** Involve nurses in first-contact perioperative screening
- **PDSA #3:** Dexmedetomidine offered to patient scoring >3

MEASURES

Outcome Measure:

- Pediatric patient's self-reported score using a standardized and validated pediatric anxiety screening tool

Process Measure:

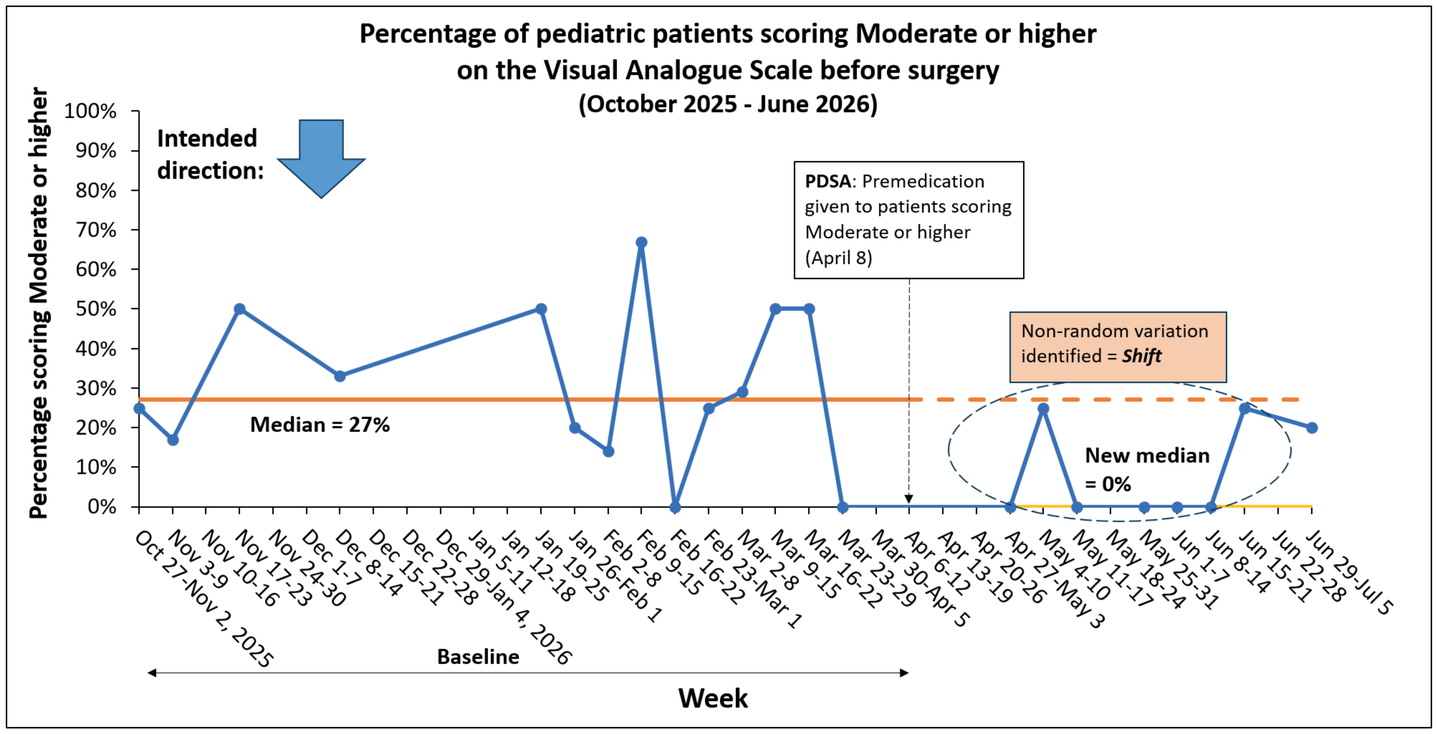
- Number of patients who received premedication

Balancing Measure:

- Length of post-anesthesia care unit (PACU) stay



**QR code for references and the full PQI Project Summary Report*



PATIENT INVOLVEMENT

A patient partner shared their experience as a parent of a three year-old who had dental surgery. They reported an overall positive experience, but noted that the waiting area could be more child friendly. Their experience highlighted the importance of varied approaches in identification and treatment across different ages of children



LESSONS LEARNED

- **Lesson #1:** Screening revealed surprising discrepancies between clinician-assessed and child self-reported anxiety
- **Lesson #2:** Using a validated screening tool limited staff's ability to modify despite some negative feedback
- **Lesson #3:** Emergence of a broader set of stakeholders than was initially apparent introduced unexpected complexities
- **Lesson #4:** Influencing workflow changes to roles other than your own is challenging
- **Lesson #5:** Positive staff experiences during PDSAs led to more generalized adoption and a formalized workflow change around screening
- **Lesson #6:** Pharmacological interventions were easier to implement than non-pharmacological change ideas like stuffed animals, blankets and virtual reality headsets

NEXT STEPS

- **Next Step #1:** Add non-pharmacological interventions to anxious children (e.g., virtual reality headsets)
- **Next Step #2:** Disseminate lessons learned and tools more broadly to other hospitals performing pediatric dental care
- **Next Step #3:** Explore passive project spread through conferences and publication

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INCREASING ADVANCE CARE PLANNING CONVERSATIONS AND DOCUMENTATION FOR PEOPLE LIVING IN SUPPORTIVE LIVING HOUSING SITES IN VICTORIA

Project Team:
Dr. Fraser Black, Lexy Stewart, Nikki Page, Char Futcher, Matthew Busby-O'Conner, Douglas Ennals, Caity Leahy, Carren Dejula, Alixandria Baxandall, Dr. Erin Flanagan, Tony Patriarch (Patient Partner)

AIM STATEMENT

To increase Advance Care Planning documentation at Mount Edwards Court (a 75-person Cool Aid Society Supportive Housing Site) to 25 people by July 2026 in both their client charts at the housing site and on Cerner Powerchart

RATIONALE

- Advance Care Planning (ACP) empowers people to express their values and care preferences before a health crisis, and is especially important for those living in poverty but often inaccessible
- Documenting ACP conversations supports continuity across emergency, primary and community services, mitigates decision-making burden on strained support networks, and promotes dignity at the end of life
- Only 1 of the 70 people living at Mount Edwards Court had a documented ACP before the project

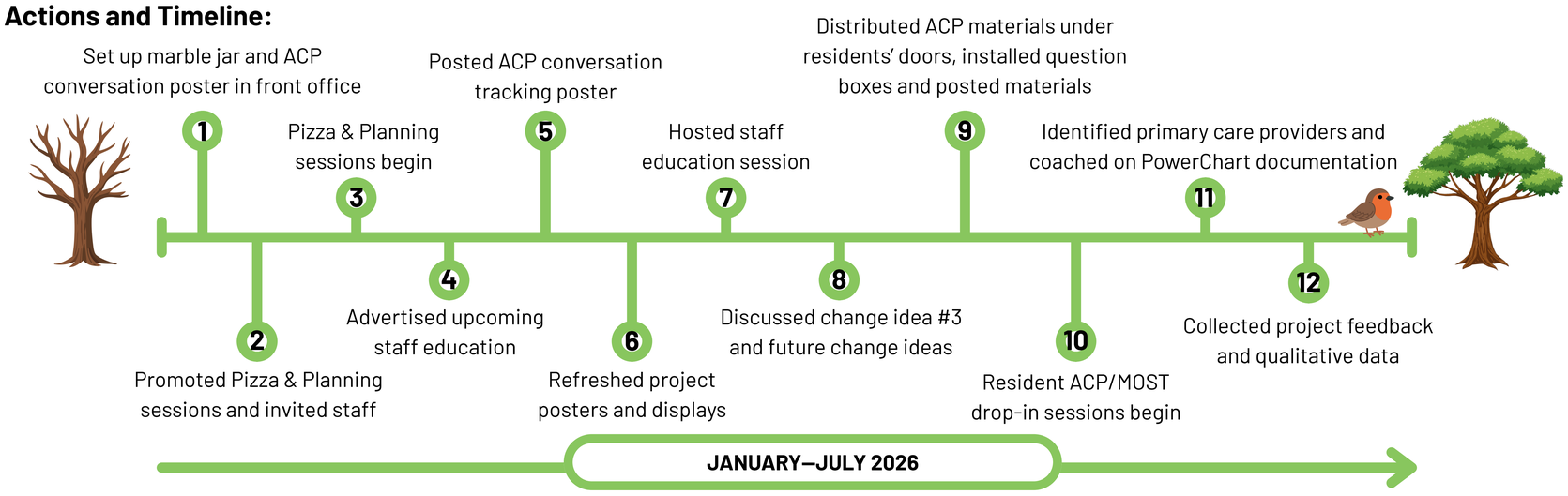
ACTION TAKEN

- **PDSA #1:** Offer group ACP information/planning sessions for residents ("Come for the Pizza – Stay for the Planning Sessions") *(ADAPT)*
- **PDSA #2:** Formal education session on ACP offered to Mount Edward staff *(ADAPT)*
- **PDSA #3:** ACP packages delivered to residents and 'Question Boxes' added to common areas *(ADAPT)*
- **PDSA #4:** Coaching patient's primary care providers on how to document ACP (ADOPT)



"And nobody likes to think of what's going to happen when they can no longer take care of themselves, but it is really important, and we don't always think these things through, so having that kind of a guide is really helpful."
- Tony Patriarch (Patient Partner)

Project Actions and Timeline:



During this project there were:

3 **ACPs documented** in Mount Edwards Court Client folders

14 **ACPs documented** in Cerner PowerChart

Note: Results reflect data collected from December 10, 2025, to July 22, 2026

There were also:

- **10** Pizza & Planning sessions
- **5** ACP/MOST drop-in sessions
- **109** clients attended ACP sessions *(total attendance)*
- **52** ACP Marble Conversations



Members of the project team at Mount Edwards Court. Left to right: Matty Busby-O'Conner, Char Futcher, Fraser Black, Douglas Ennals

For additional resources and to hear from Tony, scan the QR code!

MEASURES

Outcome Measures
- # of documents in Mount Edwards Court in Client Folders
- # of documentations in Island Health Cerner/PowerChart

Process Measures
- # of conversations had by staff/provider with people living at Mount Edwards Court
- # of ACP information sessions held (with the people living at Mount Edwards Court) and Number of people who attended
- # of ACP information sessions/sharing for housing staff members and number of staff members who attended each

Balancing Measures
- Work is - Worthwhile/Satisfying/Meaningful to me
- Confidence that people's healthcare wishes/preferences would be honoured and confidence in being able to have ACP conversations

LESSONS LEARNED

- **Demand and Engagement:** Residents wanted ACP conversations and sessions were highly engaging
- **Time and Continuity:** Ongoing sessions support engagement more effectively than one-time events
- **Relationships and Capacity:** Trusted staff were key to ACP conversations but faced time and workload constraints
- **Lived Experience and Sustainability:** Patient partner involvement provided valuable insight and strengthened sustainability
- **Primary Care Engagement:** One-on-one coaching with primary care providers supported the translation of ACP conversations into Cerner Powerchart (EHR) documentation

NEXT STEPS

- Host focus groups with project team to explore sustainability and possible project spread
- Seeking funding to scale up further ACP efforts

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UVIC | CoolAid everyone deserves home

Improving Pediatric and Neonatal Transport Safety Through Standardized Escort Training

Project Leads: Dr. Elspeth McGregor, Dr. Jeffery Bishop & Tyler Bevan
Project Participants: Thomas Manktelow, Sarah Heighington, Sharleen Steeper, Damian Lange, Trapper Edison & Suzie Vinden

AIM STATEMENT

By June 2026, increase the proportion of pediatric (0-2 years) and neonatal interfacility transports completed by trained transport-certified nurses to ≥50% for Nanaimo Regional General Hospital (NRGH) and Victoria General Hospital (VGH), improving adherence to best practice and reducing reliance on ad hoc escort teams.

RATIONALE

- Across Island Health, pediatric and neonatal patients requiring interfacility transport are frequently escorted by clinicians **without** standardized training when specialized transport teams are unavailable
- This results in variability in preparedness, equipment use, and transport safety, contributing to **increased risk** to patients, providers, and system efficiency
- While pediatric and neonatal patients represent distinct clinical groups, they share common system challenges related to staffing, training, and equipment, allowing for a **unified improvement approach**

ACTION TAKEN (PRE-IMPLEMENTATION)

1. Performed a jurisdictional scan of transport medicine best practice
2. Developed a standardized approach to pediatric and neonatal transport
3. Established training requirements with Professional Practice
4. Created recruitment materials
5. Identified interested nurses
6. Built training framework aligned with provincial standards
7. Designed a system for transport data collection and post-transport feedback
8. Secured implementation funding
9. Established training logistics
10. Defined staffing models
11. Collected project data and refine training iteratively

NEXT STEPS (IMPLEMENTATION)

- **3 nurses trained** (September 2026)
- **Soft go-live** (October 2026)
- 12. Deploy trained nurses
- **Deploy trained Island VIK-STAR teams** (December 2026)

MEASURES

Outcome Measure

- Percentage (%) of pediatric (0-2 years) and neonatal interfacility transports completed by trained transport-certified nurses (NEOSTAR/VIK-STAR)

Process Measures

- Number and proportion of staff trained and validated in pediatric/neonatal transport
- Percentage of shifts with ≥1 trained transport nurse available
- Percentage of transports where required equipment is available and use appropriately

Balancing Measures

- Transport time (e.g., delay from request to departure)
- Provider workload and staffing impact at sending sites
- Adverse events or safety incidents during transport



DID YOU KNOW?

Training 8 clinicians annually costs less than a single helicopter transport from Comox, Port Alberni or Campbell River to Victoria. At $848 per trip, ground transport offers substantial system savings compared to helicopter transfer ($4,394/hr)

LESSONS LEARNED

- Sustainable change requires early operational alignment and ongoing support of trained staff to avoid burnout
- Stadardization requires collaboration with groups provincially and across the country in terms of outcome measures and team composition
- Pre-implementation work is critical for success

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Improving Community Access to Biopsy Clinic

Dr. Jill Stone (Physician Lead), Kylie Peake (FLEX Student), Candace Kuhn (Medical Office Assistant),
Adrienne Schmidt (Clinic Manager & Medical Office Assistant), and Dr. Carley Cooper (Physician Partner)

AIM STATEMENT

To increase number of skin biopsies in office by 100% by April 2026

RATIONALE

- Patients with suspicious skin lesions require biopsy before plastic surgery referral, yet 12.7% of British Columbians lack access to a family physician to arrange or perform this
- Nanaimo Regional General Hospital (NRGH) currently biopsies undiagnosed lesions referred to our clinic, using limited resources
- Community biopsy capacity is constrained by cost, time and office set-up barriers
- Referrals without biopsy are often declined, increasing administrative burden and delays to diagnosis and treatment

MEASURES

Outcome Measure:
- Number (#) of in office biopsies

Process Measures:
- Number (#) of skin lesion/cancer consults and follow ups seen in the office per month
- Cost reduction of office biopsies
- Number (#) of saved minor surgery minutes for alternative surgeries

Balancing Measures
- Breast reduction encounters per month
- Workplace satisfaction (self and employees)

PDSA #1: Open Access to Unbiopsied Lesions

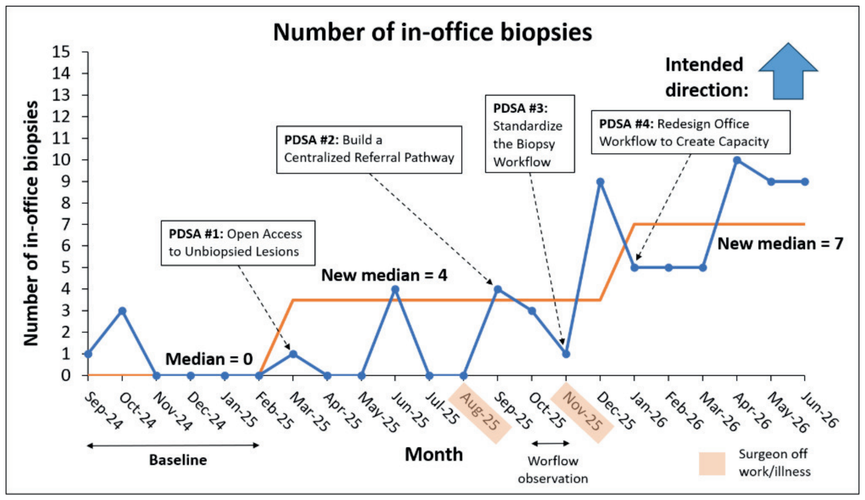
PDSA #2: Build a Centralized Referral Pathway



PDSA #3: Standardize the Biopsy Workflow

PDSA #4: Redesign Office Workflow to Create Capacity

ACTION TAKEN



PRE-OPTIMIZATION

Cost of each biopsy tray

$52.97



POST-OPTIMIZATION

Cost of each biopsy tray

$22.22

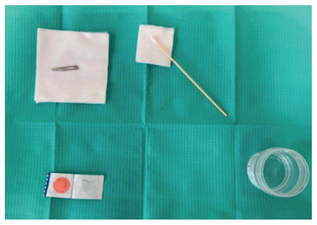


*photo excluding gloves and anesthesia

A **58.05%** reduction in biopsy tray costs was achieved following **PDSA #4**

The cost of minor surgery is **$688 per hour** at NRGH



Year & Semi-Annual	NRGH minor surgery minutes for skin biopsies	Hospital Cost ($)	Cost Savings *(vs 2024 S1)*
2024 (S1)	310	$3,554.67	-
2024 (S2)	185	$2,121.33	**$1,433.34** *(40.3% reduction)*
2025 (S1)	135	$1,548.00	**$2,006.67** *(56.4% reduction)*
2025 (S2)	70	$802.67	**$2,752.00** *(77.4% reduction)*
2026 (S1)	**0**	**$0.00**	**$3,554.67** *(100% reduction)*

As of June 2026, **100%** of unbiopsied lesions are managed in office, redirecting minor **surgery capacity and cost to definitive care**

"It's so nice to have this clinic" *-Patient #1*

"Good thing we can come here to get answers" *-Patient #2*

"I'd much rather come to your office than go to the hospital" *-Patient #3*



LESSONS LEARNED

- Clinic costs continue to be a barrier to in-office biopsies
- Workflow improvements increased capacity without added work hours
- Patient-centred care may incur additional provider and hospital costs
- Measuring total system savings remains complex
- Successful spread is possible —A new locum completed >40 biopsies in August 2026

NEXT STEPS

- Educate providers and expand to other offices
- Maintain biopsy waits to under 30 days
- Improve practice efficiency using lessons learned

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Reducing Time to Completion for Non-Urgent Referrals

Project Team: Physician Lead: Dr. John Kim (Family Physician)
Project Sponsors: Annie Lucas (Director of Health Services), Dr. James Felix (Family Physician Lead), Paula Leahy (Associate Director of Operations)

AIM STATEMENT

By May 31, 2026, 100% of the Non-Urgent Referrals will be completed within 7 days after a visit with Dr. John Kim at the University of Victoria, Student Wellness Centre (SWC)

RATIONALE

- Post-secondary transition challenges can affect student well-being and academic success, with 75% of Canadian students reporting mental health concerns
- The University of Victoria, Student Wellness Centre (SWC) serves approximately 22,000 students
- SWC Health Services managed 3,000 visits between September 2024 and August 2025
- Non-Urgent Referral wait times can exceed four weeks, negatively affecting student function and academic performance

MEASURES

Outcome Measure
- Bi-weekly average number of days to complete Non-Urgent Referrals after the visit date

Process Measures
- Time to complete 15 and 30-minute visits (minutes)
- Time to complete the visit note (minutes)

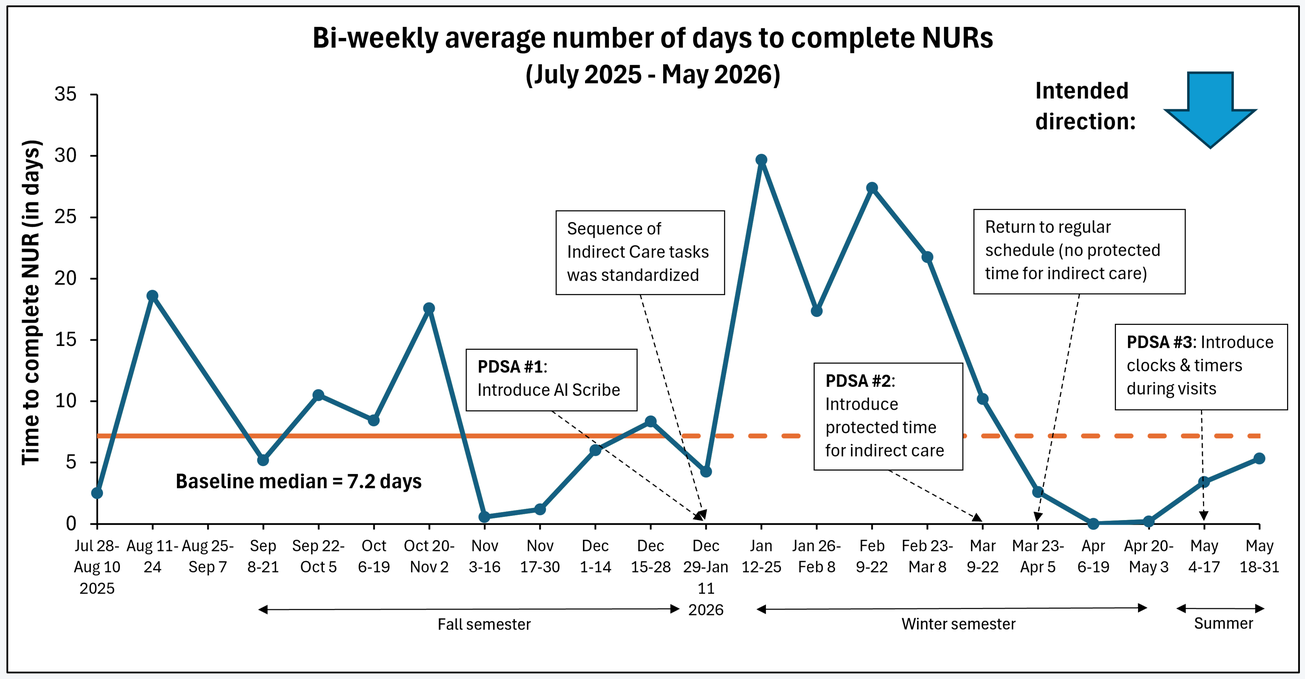
Balancing Measures
- Clock out of work time
- Practitioner self-report of happiness score out of 5
- Student survey to whether they felt supported by their practitioner during the visit

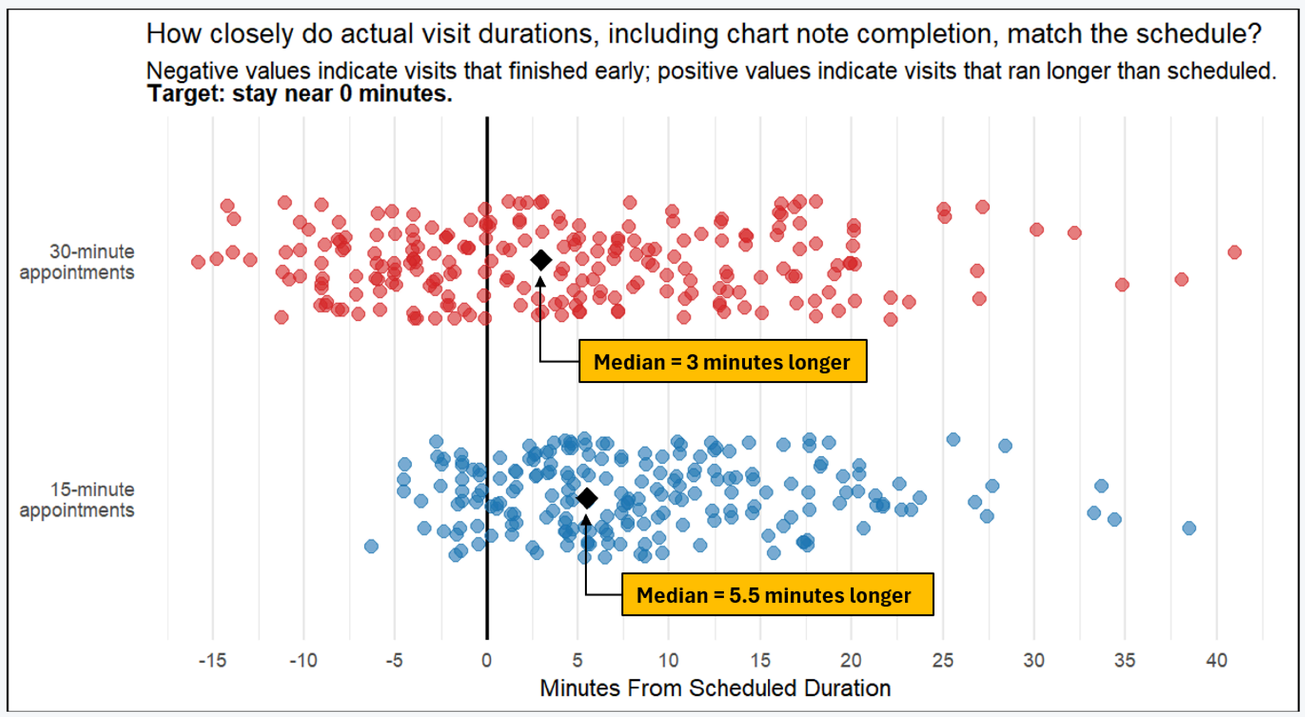
ACTIONS TAKEN

PDSA #1: Integrated Heidi AI Scribe using standard templates after obtaining student consent **(*Adopted*)**

PDSA #2: Episodic conversion of unused appointment blocks into protected indirect care time to complete tasks including writing referrals **(*Adapted*)**

PDSA #3: Deployed physical and virtual clocks and timers to support in-visit time management **(*Adapted*)**





NEXT STEPS

- Continue to use a clock and explore its placement in the examination room (PDSA #3)
- Explore future ideas related to managing student expectations surrounding a visit
- Evaluate suitability of Non-Urgent Referrals as the patient-centred outcome measure
- Explore alternative strategies to manage the schedule and apply PDSA principles

LESSONS LEARNED

- Heidi AI scribe alone was insufficient to achieve the project aim
- Increasing indirect-care time had the greatest impact but lessened appointment availability
- This highlights that physician practice habits alone may not be sufficent and other factors may need to be addressed, such as patient/student factors and scheduling targets.
- Most visits use or exceed the scheduled time, limiting time for referral completion
- Changes did not reduce students' sense of support during visits

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OPTIMIZING PATIENT REFERRALS TO P.R.O.P.:
THE PRESURGICAL RESILIENCE & OPTIMIZATION PROGRAMME

Project Leads: Dr. Karen Johnsson & Dr. Sonja Mathes

Project Team: Leah Jones, Jessica Sharcott, Michael Dingle, Amy McCoy, Ash Lawson

RATIONALE

- RebalanceMD in Victoria, BC, offers an optional eight week Presurgical Resilience and Optimization Program (PROP) for patients undergoing major orthopaedic surgery. PROP is an online Group Medical Visit.
- Up to 36% of patients undergo surgery before completing the 8-week program
- Delays in referral and enrollment occur after patient are placed on the surgical waitlist
- Earlier referral to PROP could improve program completion and surgical readiness

AIM

By June 2026, 95% of Preoperative Resilience and Optimization Program (PROP) patients will complete PROP before their surgical date

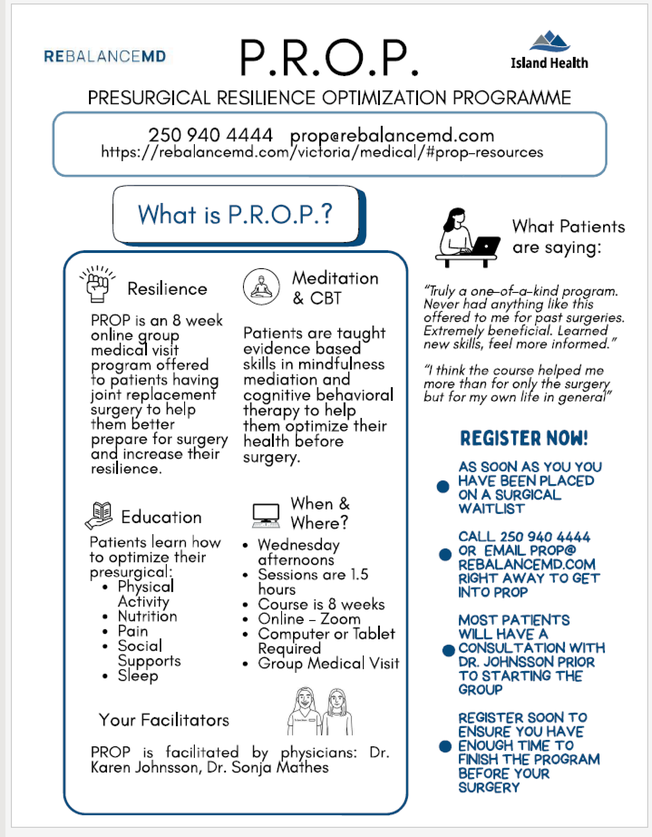
ACTION TAKEN

Healthcare team oriented PDSAs:

- Meeting Admin Assistants/Navigators/OR bookers to increase awareness of importance early enrollment
- PROP information added to Pathways BC and consult letters

Patient oriented PDSAs:

- Adapted patient facing materials with multipronged approach to emphasize the importance of early referral PROP
- Allowed patients to self initiate their referral to PROP
- PROP information video created and posted on website with flyer



MEASURES

Outcome Measure

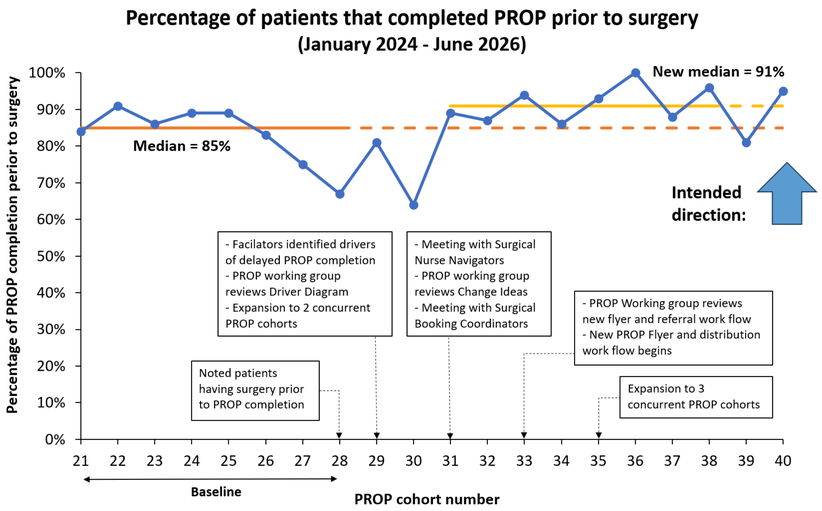
- Percentage (%) of patient per cohort that have completed PROP prior to their surgical date

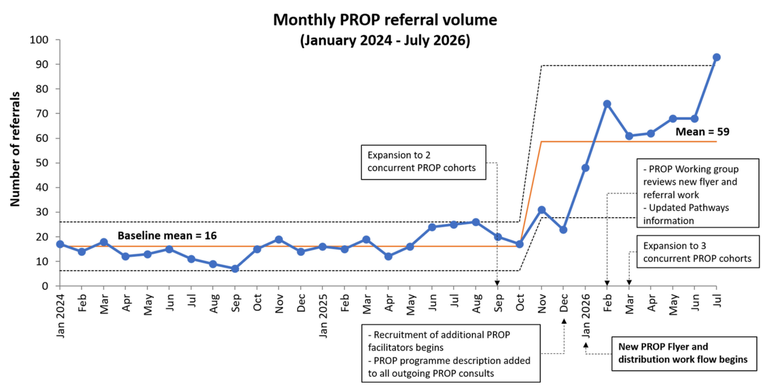
Process Measures

- Wait time between Surgical Waitlist entry and PROP referral
- How patients found out about/are getting referred to PROP (Patient Survey)
- PROP website hits

Balancing Measures

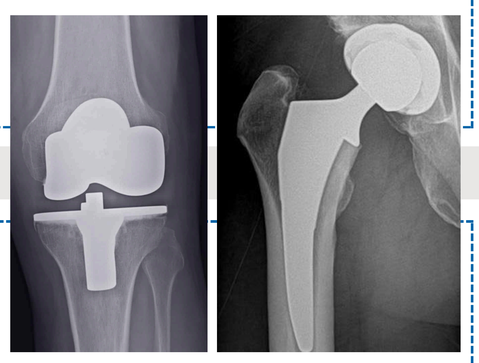
- Number (#) of patient referrals
- Number (#) of cohorts & patients per cohort
- Delay from PROP referral to PROP intake





LESSONS LEARNED

- Majority of PROP patients were referred via their surgeon historically. Self referral increased timeliness and volume of referrals.
- Prioritizing PROP flyer amongst other surgical booking information increased PROP referrals
- Spreading information about PROP widely through the organization increased referrals
- Systemic change benefits from input of all team members
- Significant increased referral volume required significant time and attention - this may contribute to delays at different points in the PROP journey.



NEXT STEPS

- Routine data reporting now occurs monthly regarding PROP referrals, consults, wait times and program completion prior to surgery.
- Further QI initiatives have started to address increased PROP capacity - recruiting more facilitators, creating a facilitator package, exploring alternative delivery models.
- We continue to review PROP evaluations during all changes.

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REBALANCEMD

Reducing Low-Value Follow-Up Blood Cultures in Gram-Negative Bacteremia at Royal Jubilee Hospital

Dr. Mohammed Sarhan, Dr. Xiaofeng Ding, Ryan Kletke, Claire Belanger, Catriona (Katie) Hopper, Rachael Montgomery

AIM STATEMENT

By June 30, 2026, reduce the proportion of patients with Gram-negative bacteremia (GNB) who receive follow-up blood cultures (FUBC) at Royal Jubilee Hospital (RJH) by 20%



PATIENT ENGAGEMENT

A patient partner highlighted that patients often do not understand the purpose of blood tests, making appropriate test ordering a clinician responsibility. This reinforced the need to reduce unnecessary testing to improve care and lower costs

RATIONALE

- Follow-up blood cultures (FUBC) in GNB have low diagnostic yield, with approximately 95% returning negative results
- Routine FUBC are not reccomended in uncomplicated cases and are associated with increased hospital length of stay, greater antimicrobial exposure and higher healthcare costs
- At Royal Jubilee Hospital, more than 50% of patients with GNB undergo follow-up blood cultures
- Approximately 95% of these blood cultures are negative and contributed approximately $300,000 in laboratory costs since 2023

MEASURES

Outcome Measure

- Percentage (%) of FUBC for GNB-positive cultures at RJH

Process Measures

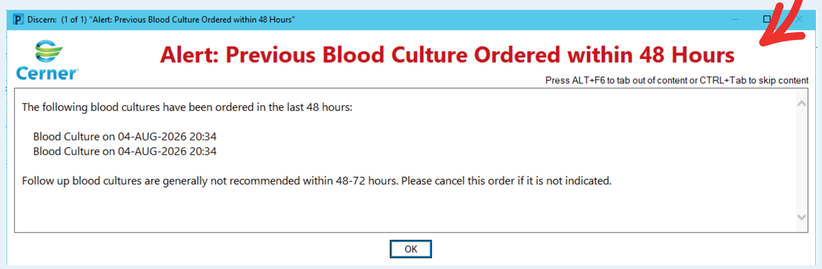
- Number (#) of education sessions to ordering physicians
- Number (#) of ordering physicians attending education sessions

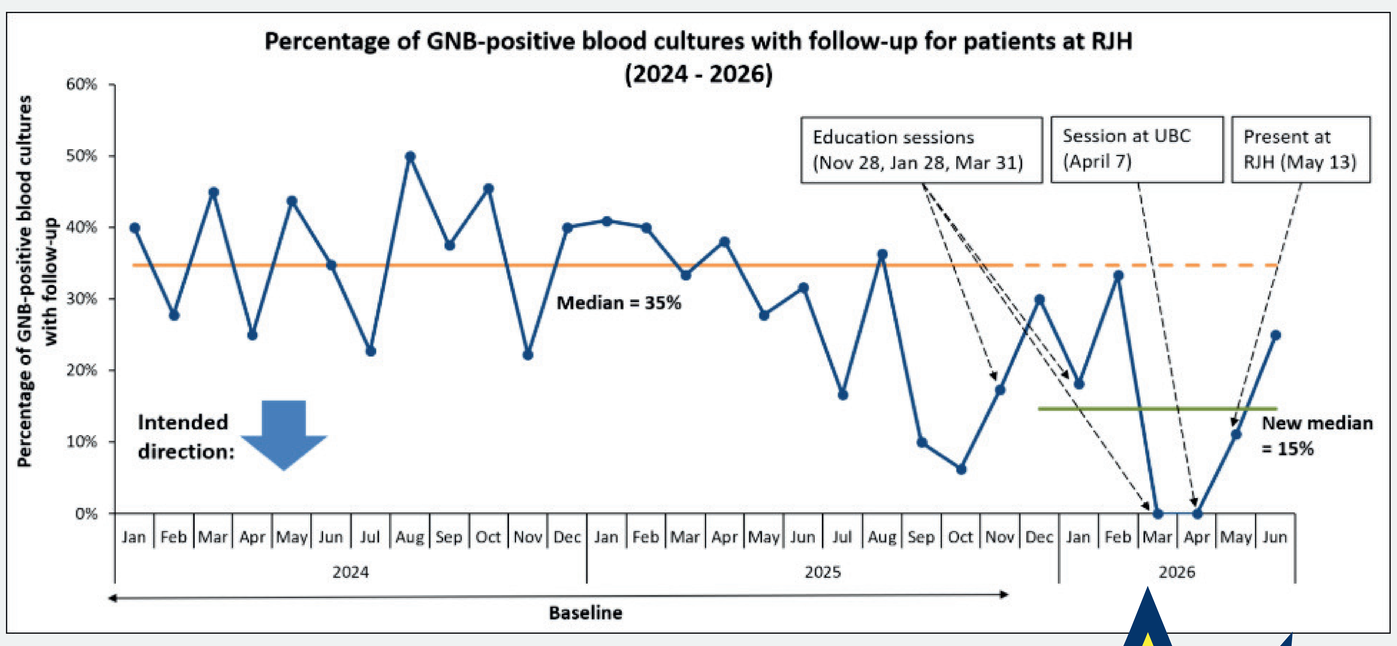
Balancing Measures

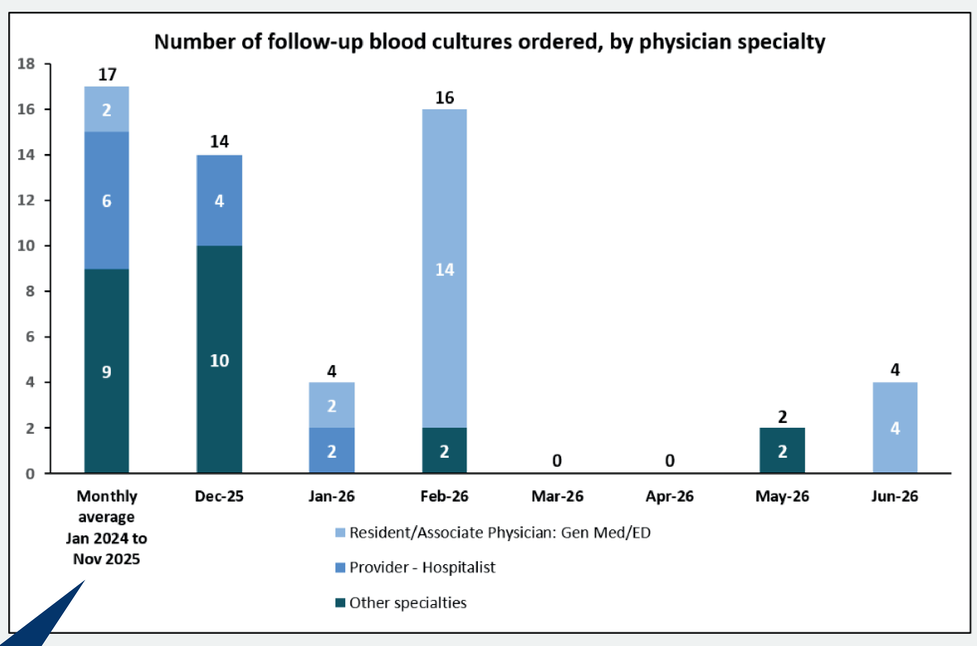
- Percentage (%) of necessary FUBC missed
- Ordering physician feedback

ACTION TAKEN

- **PDSA #1:** Targeted education for ordering physicians
- **PDSA #2:** Standardized comment reminder added to blood culture results that repeat cultures may not be needed
- **PDSA #3:** Electronic Health Record (EHR) reminder when a repeat blood culture is ordered within 48 hours







LESSONS LEARNED

- In-person education works best at it allowed discussion, answered questions and built trust
- Clinicians need clear evidence to reduce FUBC and support their decisions
- Simple reminders help reduce unnecessary tests without causing alert fatigue

A reduction of approximately 79 follow-up blood cultures over 7 months resulted in an estimated cost savings of **$7,900**

NEXT STEPS

- Operationalize ongoing education sessions for evidence-based lab ordering best practices
- Implement EHR alerts to reduce blood cultures across all patient populations
- Scale project beyond Gram-negative bacteremia to support sustained behaviour change and reduce unnecessary testing and resource use

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SSC Specialist Services Committee | PQI Physician Quality Improvement Specialist Services Committee | island health

Improving Hepatitis C Virus Identification Among Structurally Vulnerable People in Campbell River

AIM STATEMENT

By June 30, 2026, participating Campbell River Outreach Team clinicians will have tested 80% of patients for Hepatitis C Virus (HCV) antibody who have not been tested within the last year.

RATIONALE

- Untreated HCV infection can cause cirrhosis, liver failure, and liver cancer, leading to **high morbidity, mortality** and **health care costs**
- **Hepatitis C treatment is highly effective**, lasts only 8-12 weeks, and has minimal side effects
- Stigma, racism, unemployment, unstable housing, poverty, and care gaps limit access to HCV care
- The BC Center for Disease Control recommends **annual testing** for people with ongoing risk of infection
- Competing health priorities in Campbell River Outreach team often lead to missed annual HCV screening
- Currently, **only 55% of eligible patients** seen by the Campbell River Outreach team receive annual HCV antibody screening test

"I'm going down the right path now. You know, I mean, I'm aware of what I need to do and what I have to do, which I was never aware of before."

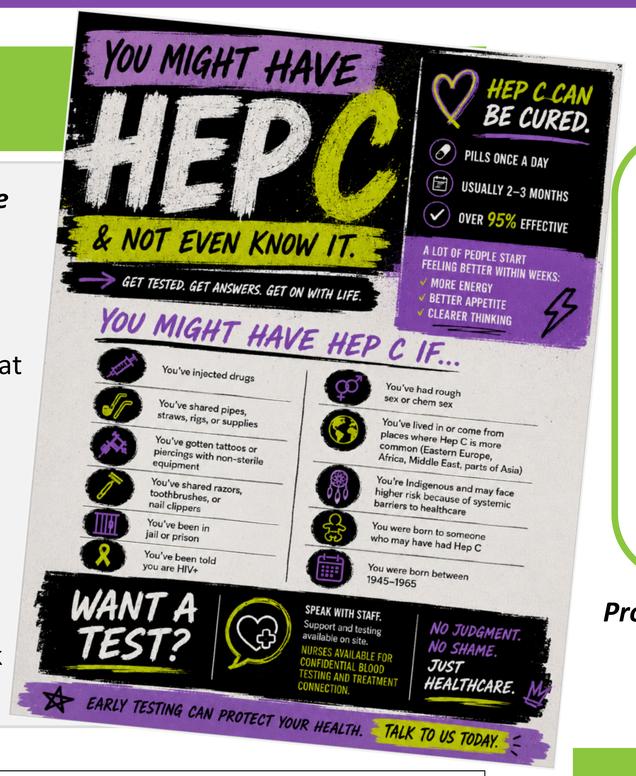
Patient Partner

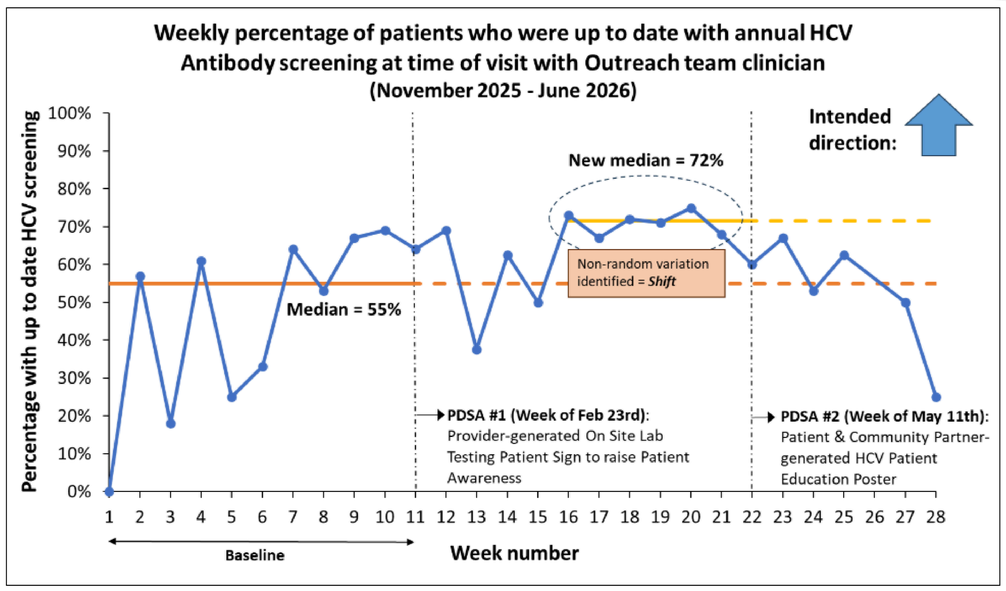
"Attaching a peer who's been through treatment, I think, is like...bare minimum"

Patient Partner

ACTION TAKEN

- **PDSA #1 (*Provider-Generated On Site Lab Testing Sign to Raise Patient Awareness)*:** Laminated green sign stating "Doctor/Nurse In! Laboratory testing available today" to be placed at a conspicuous space at two sites
- **PDSA #2 *(Patient & Community Partner-Generated HCV Patient Education Poster)*:** Laminated community and patient partner-designed sign to raise patient awareness. It was posted on the back of bathroom stalls at two sites.





Note: baseline was skewed by variation in weekly patient encounters. However, PDSA #1 data is encouraging and provides confidence in patient awareness and education changes

"While the primary objective was to increase Hepatitis C testing, the initiative also enhanced overall screening practices. Increased awareness among providers and clients facilitated conversations about broader health needs, resulting in more comprehensive assessments and increased screening for additional conditions, ultimately improving preventive care and early intervention."

Project Team Member & Provider

METHODS

Outcome Measure

- Percent of patients seen by Campbell River Outreach Team physician or nurse tested for Hepatitis C Virus Antibody (HCV Ab) in the last year

Process Measure

- Percent of patients provided a laboratory requisition for HCV Ab testing

Balancing Measures

- Percent of providers taking extra time outside of regular work hours to collect data for project
- Percent of providers taking time away from patient care to collect data for project

LESSONS LEARNED

- Laminated signs were ineffective for clinicians working in mobile settings
- Patient and community partners helped quickly develop patient-centered change ideas
- Data collection resulted in increased work hours for some clinicians
- Participation in this QI project increased use of other recommended screening tests
- QI work strengthened team relationships through shared problem-solving and collaborations
- Cerner could improve care coordination for highly mobile, structurally vulnerable patients, but access barriers remain for some clinicians

NEXT STEPS

- Work with our diverse team to improve HCV screening among patients seen by mobile Outreach clinicians
- Continue to collect and assess data for the sites where the patient education bathroom signs have been posted (PDSA #2)

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DOWN:

Decrease Outpatient Wait-times in Nanaimo for Urgent Pediatric Patients

PROJECT TEAM:
Dr. Zaneta Lim, Dr. Sharon Choopa,
Laura Foran, Kelly Cox and Kelsey Chandler

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Rationale

- Our central intake receives ~125 referrals/month
- These are assessed by a team of seven pediatricians at a current capacity of ~54 new referrals/month
- All triage catergories are experiencing significant wait times
- In particular, patients referred to be seen within one month, were waiting an average of 59 days (nearly *double* the intended target)

Aim Statement

Decrease average wait times for pediatric outpatient one-month referrals triaged to be seen from 59 days to 31 days by June 2026.

Measures

This project covered referrals triaged for a one-month appointment across the Nanaimo Paediatric Central Intake (7 full-time pediatricians), monitored using data pulled from Accuro EMR by the Central Intake data team:

Outcome Measure:
- Average wait time to be seen by a pediatrician

Process Measures:
- Number of new “one month” referrals triaged
- Triage accuracy

Balancing Measures:
- Wait time for “within 3 months” referrals
- Patient satisfaction around communication of wait times

Next Steps

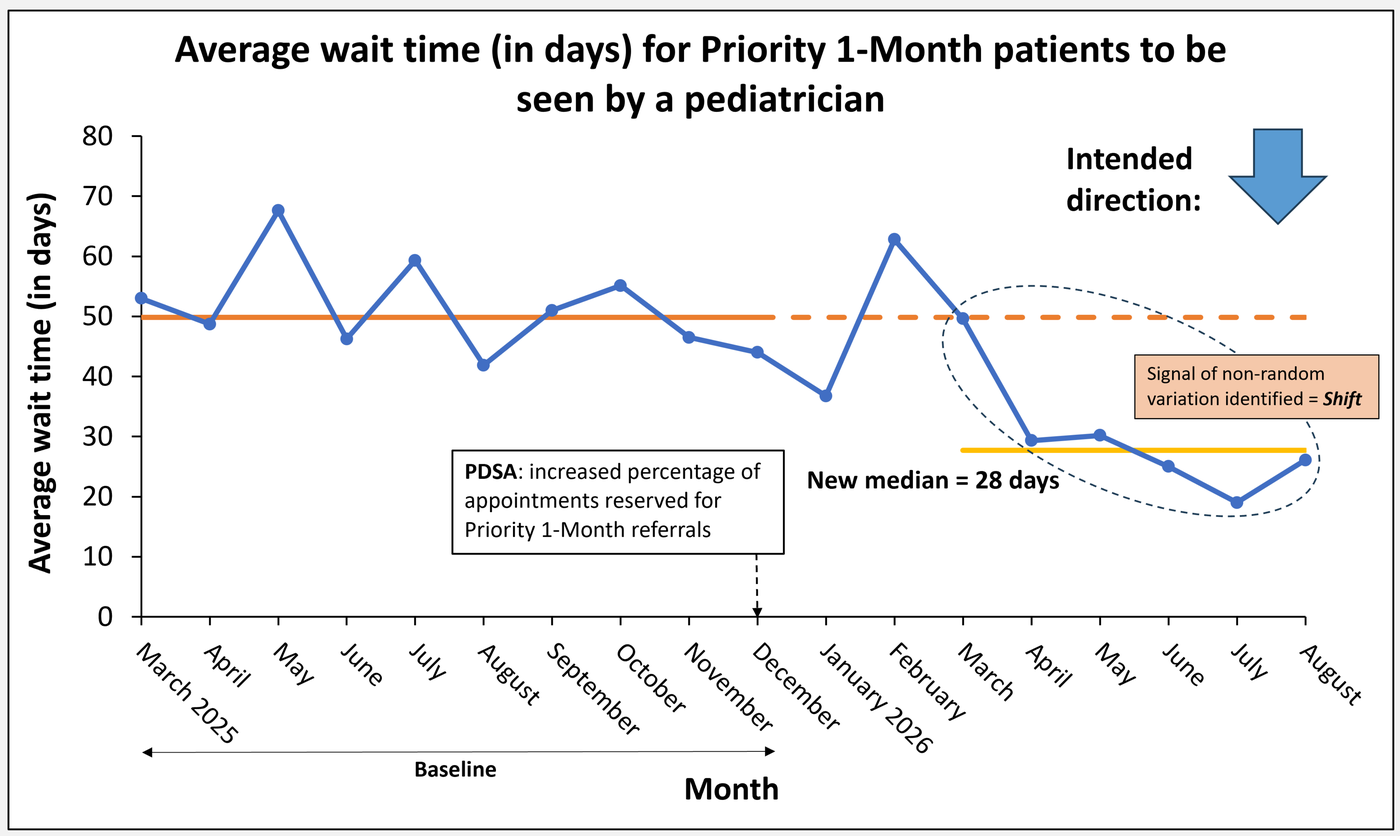
- Begin to formalize succsesful changes tested around increased appointments as standard practice
- Interest in designing a family/community experience survey

Action

In December 2025, the team tested a PDSA to increase the percentage of appointments reserved for referrals triaged to be seen within 1 month.

Wait times have trended down since this change, with 4 consecutive months reaching below the baseline median

Adopted!



Lessons Learned

- Monthly wait times were highly variable even during the baseline period (37–68 days) given low monthly referral volume (5–13/month), reinforcing the value of a run chart over a single before/after comparison. Despite this variability, the outcome measure demonstrates a shift!
- Also of note is the December 2025 increase in appointments reserved for <1-month referrals (Physician Capacity driver) which coincides with the sustained decline in wait times from March–June 2026.
- Scoping the project to target 1-month referrals and a balancing measure of 3-month referrals was a necessary decision to enable our project to be run within a PQI cohort while building future capacity to test improvements across triage groups down the road.
- Patient and family partners were not engaged in this project cycle, limiting insight into the lived experience of the wait times being addressed.

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Reducing Delays and Improving Safety for Older Adults in Triage Hold

Dr. Stephanie Niles (Project Lead), Rebecca McGregor (Project Lead), Dr. John Boldon (PQI Alum), Raelene Neff (Clinical Nurse Educator),
Damian Lange (Executive Sponsor) & Susan Barr (Patient Partner)

AIM STATEMENT

By June 2026, reduce the average time from triage to disposition decision (admit, discharge, or transfer) from 6.33 hours to 5.0 hours for patients ≥ 65 years who spend time in the Triage Hold area of the Nanaimo Regional General Hospital (NRGH) Emergency Department (ED)

RATIONALE

- Older adults make up 60% of ambulance arrivals at NRGH and are a high-risk ED population
- Many admitted older adults wait 33+ hours for an inpatient bed, often in Triage Hold
- Delays in assessment and treatment in Triage Hold increase the risk of preventable harm
- Since January 2026, two serious patient safety events involving older adults in Triage Hold have been reported at NRGH

ACTION TAKEN

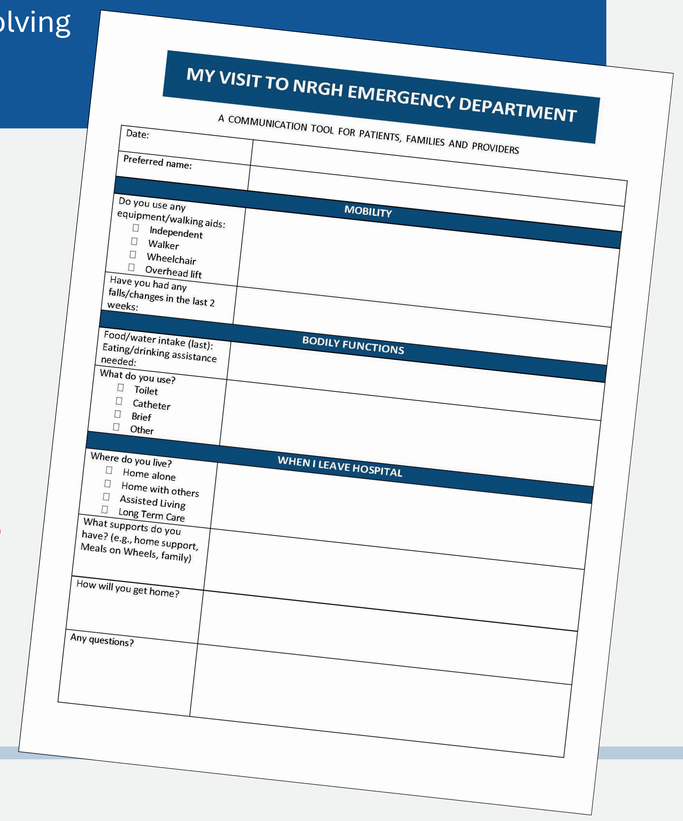


PDSA #1: Additional Licensed Practical Nurse (LPN) in Triage Hold Area *(Adopted)*

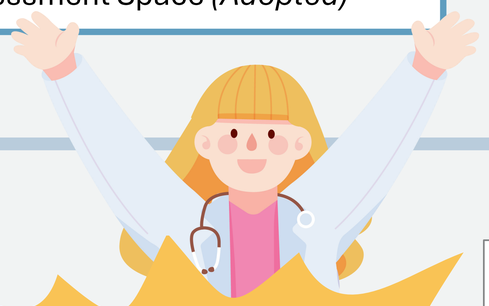
PDSA #2: Pre-Hospital Functional Screener Form *(Adopted)*

PDSA #3: Emergency Medical Services (EMS) Alcove as Assessment Space *(Adopted)*

Patient partner feedback improved the usability and patient-centeredness of the Pre-Hospital Functional Screening form



MEASURES



Outcome Measures

- **Primary Outcome:** Time from triage to disposition (hours)
- **Secondary Outcome:** Hospital related harms (PSLS)

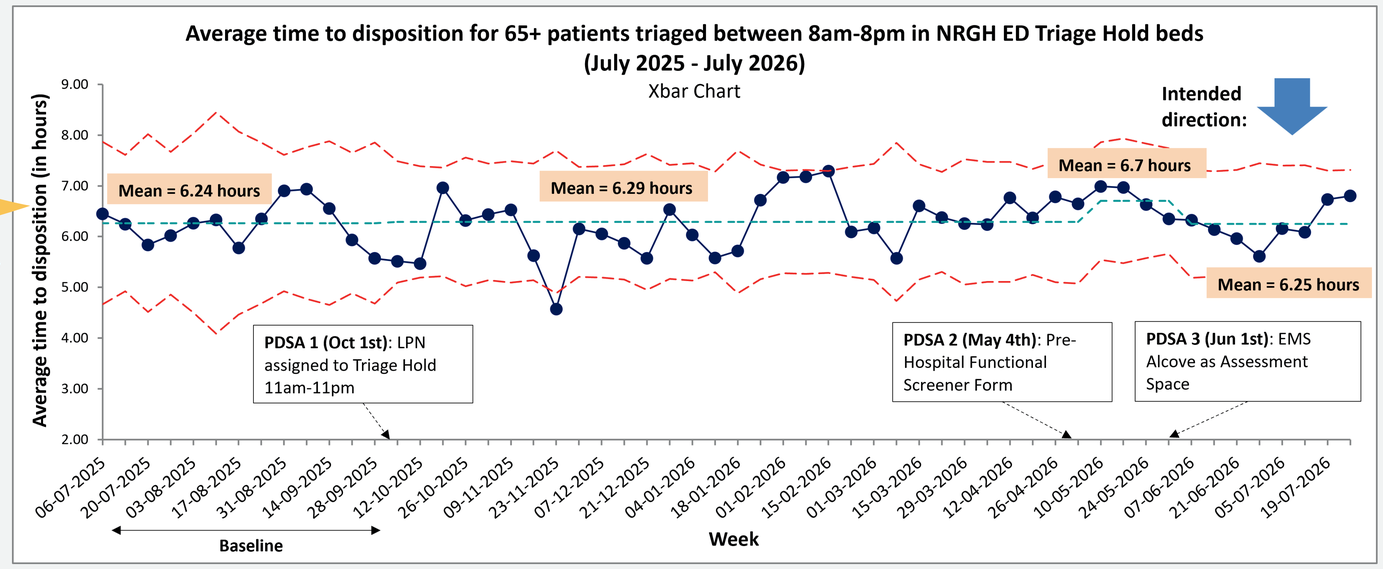
Process Measures

- Time to documented physician sign up (hours)
- Time to documented nursing assessment (hours)
- Percentage (%) of patients with repeat vital signs

Since February 2026, **no serious harm events have occurred** among patients in Triage Hold

Balancing Measure

- Time to documented physician sign up for similar patients outside of Triage Hold



LESSONS LEARNED

- Dedicated nursing presence may improve safety, though inconsistent LPN coverage likely limited the intervention's impact
- Time to physician assessment is not a primary driver of delay
- Physical environment may influence flow
- Functional assessment supports best practice
- Frontline engagement enables implementation of intereventions



NEXT STEPS

- Implement the Pre-Hospital Functional Screening Form across the ED
- Streamline the admission process after the decision to admit
- Expand the use of the EMS assessment alcove to improve patient flow
- Integrate functional screening into the EMR to support care planning and disposition decisions

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