MAiD REFERRAL ENHANCEMENT:
Improving the Processes in Medical Assistance in Dying

Physician Lead: Dr. Diane Wallis

Location: Nanaimo ***Specialty:*** MAiD Practitioner

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

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 of Project:

- 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.

Change Idea:

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

Patient Voice:

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

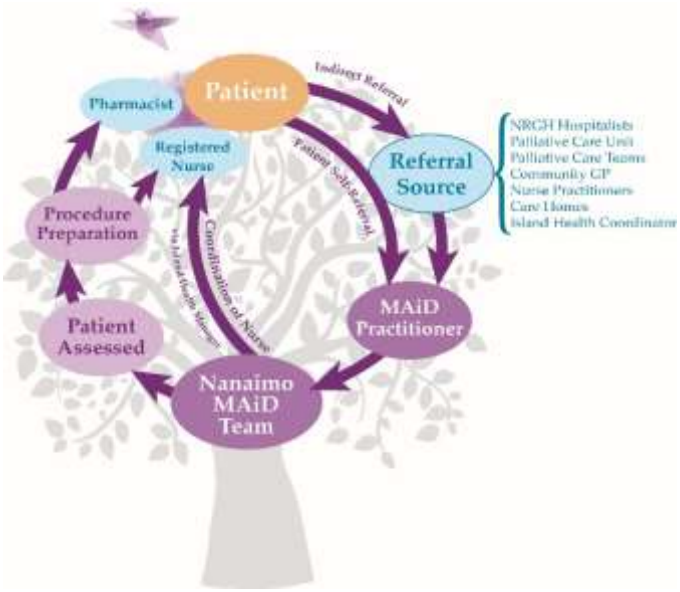
PDSA Cycle:

Survey Design

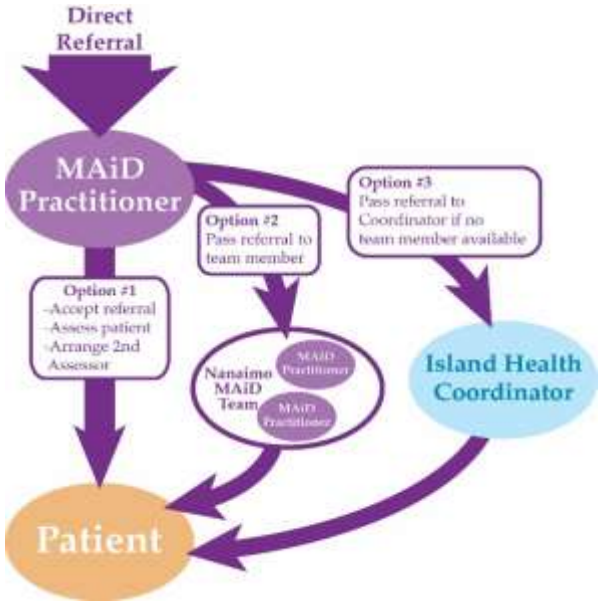
- Plan: Survey of GPs for educational need
- Do: Collaborate with Nanaimo Division if Family Practice (NDFP)
- Study: GPs want MAiD info from NDFP
- Act: Work with NDFP to add info to website

Process Map Diagrams:

Nanaimo MAiD Patient Referral Pathway



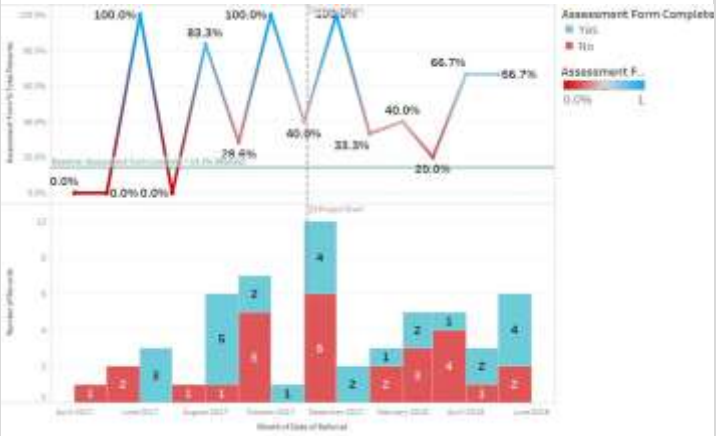
Nanaimo MAiD Team Internal Referral Process



Process Map Diagrams:

Nanaimo MAiD Patient Referral Pathway

Nanaimo MAiD Patient Referral Pathway



Conclusions:

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.

Implementing Surgical Early Pregnancy Loss Management in the Emergency Department

Physician Lead: Dr. Regina Renner

Location: Nanaimo ***Specialty:*** OB/GYN

Background:

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

Problem:

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

Aim of Project:

Primary Aim:
Decrease the time from ED presentation for EPL to discharge after a uterine aspiration from 26hrs (Oct 2016-Apr2017) to less than 5hrs by July 2018

Secondary Aims:

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

Change Idea:

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

- Uterine aspiration with local anaesthesia (provided by gynaecologist)
- Under IV sedation (provider by the proceduralist) in the ED

PDSA Cycle:

Small Test of Change:

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

Patient Voice:

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

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

Data Analysis:

Outcome measures:

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

Process measures:

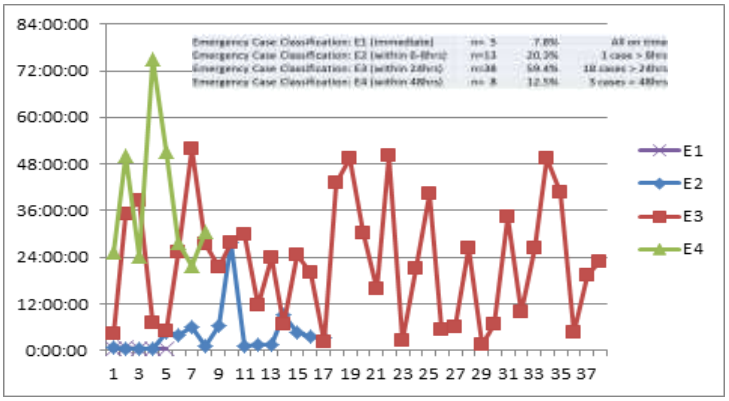
- Wait time from OR boking to entering OR
- Wait time from procedure end to discharge
- Number of women undergoing uterine aspiration in ED vs OR
- Staff satisfaction and experience
- Cost

Balancing measures:

- Complications, ED resources

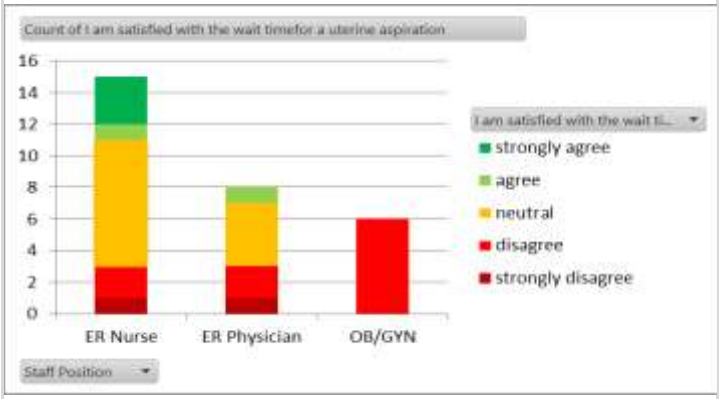
Wait Time: OR Booking to OR Entry

Retrospective and Prospective data;
combined as not substantially different, n=64)



Pre-Implementation Staff Survey

"I am satisfied with the wait time for a uterine aspiration"



Findings:

1. Almost 50% of E3 and E4 procedures exceed their set time limit
2. 95% women are satisfied with the overall service, but only 64% are with wait times
3. Physicians are especially not satisfied with the wait time
4. One procedure done in the ED (2hr wait time); patient satisfied; review with staff identifies need for more education on gynecology procedures
5. At least 5 other procedures declined by the ED due to staff and resource shortage
6. 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.

Woman-Centered Care for Early Pregnancy Loss

Physician Lead: Dr. Maki Ikemura

Location: Duncan ***Specialty:*** Maternity Care

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

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.

Patient Voice:

Before project initiation:

- *"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."*

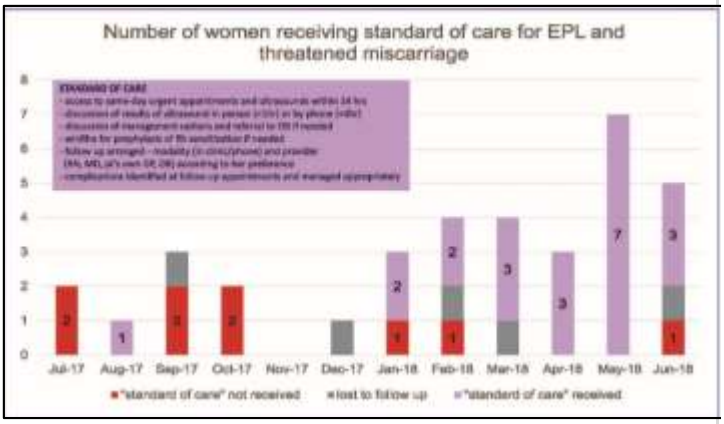
After project initiation:

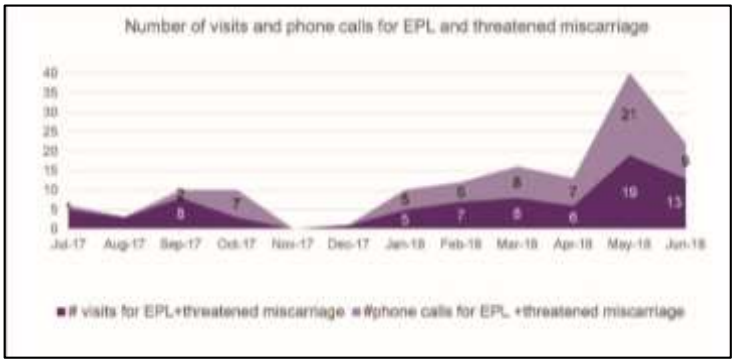
- "The Welcome Visit is a great idea- women can know where to go when they have concerns."
- "I appreciated how the Maternity Clinic got me in to see a doctor and organized an ultrasound for me right away."
- "In a bad situation it feels better if you have choices, I liked being offered follow up by phone or in person at the clinic."

Change Ideas:

- Any provider can arrange urgent ultrasound and lab – BCGuidelines.ca: Ultrasound prioritization, May 30, 2018
- Women with early pregnancy concerns seen with same day appointments
- Women offered as much follow up as needed after early pregnancy loss
- Care Card sleeve with clinic stamp will prompt ER/Lab/US to Cc reports to clinic
- Early "Welcome Visit" with clinic dietician – orientation and info package
- Algorithm will standardize care
- New Cowichan Maternity Clinic (CMC) brochure outlines what to do when bleeding in early pregnancy
- Radiology to automatically rebook follow up scans when needed

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

Conclusions:

- 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

Improving Preterm Labour Testing:
An Evidence-Based & Data Driven Approach

Physician Lead: Dr. Michael Chen

Location: Victoria ***Specialty:*** Laboratory Medicine

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.

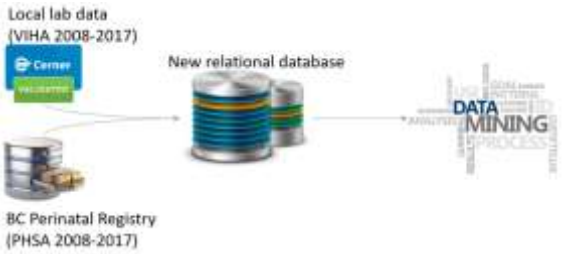
Problem:

- 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.

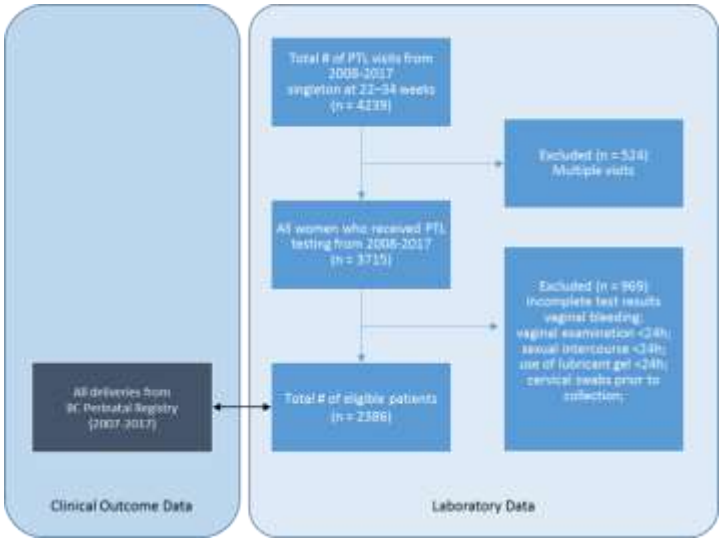
Aim of Project:

- 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 Analysis:



Findings:

(n=4374)	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.

Improving MINS Monitoring:

Better Screening for Myocardial Injury after Non-cardiac Surgery

Physician Lead: Dr. Kevin Yee

Location: Victoria ***Specialty:*** Anesthesia

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 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%

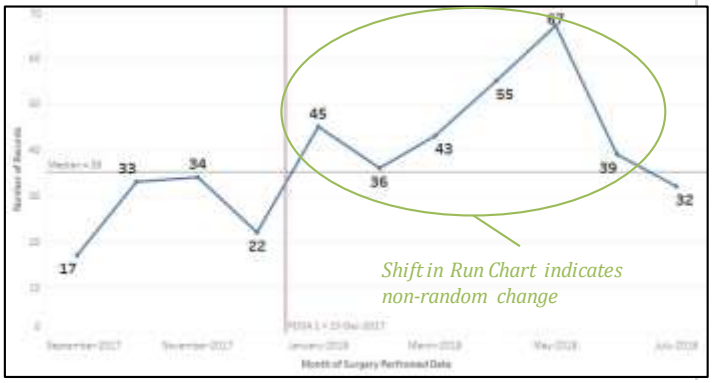
Change Idea:

- 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

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 Age 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

Patient Voice:

- "I never know a heart attack could be silent"
- "Thank you for making sure that my surgery and recovery goes smoothly"

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.

Capturing Cannabis:
Improving Cannabis Disclosure on Hospital Admission

Physician Lead: Dr. Matthew Moher

Location: Victoria ***Specialty:*** Hospitalist

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

Problem:

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

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

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

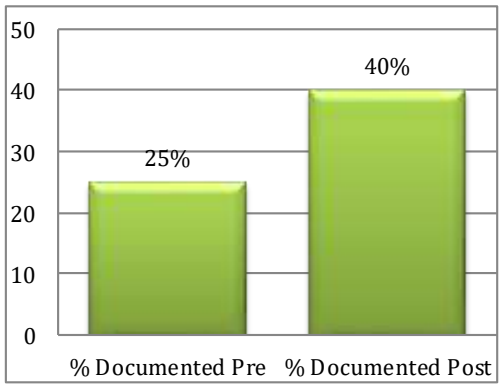
- Improve capture of use on admission to Hospitalist service at RJH by 75% in 8 months
- Better understand patient perspective
- Address educational gaps
- Drive sustainability of the improvement

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

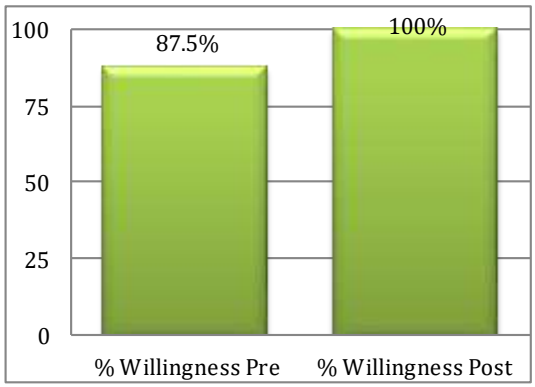
Data Analysis:

Intervention Comparison
Pre/Post Cannabis Documentation



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



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

Findings:

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

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.

Let's Talk About What Matters Most:
Serious Illness Conversations in Hemodialysis Care

Physician Lead: Dr. Christine Jones

Location: Victoria ***Specialty:*** Palliative Care

Background:
Patients in the final year of their 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.

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 of Project:
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 Cycle:
- **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 Survey -** Patient centered perspective on End-of-Life conversations

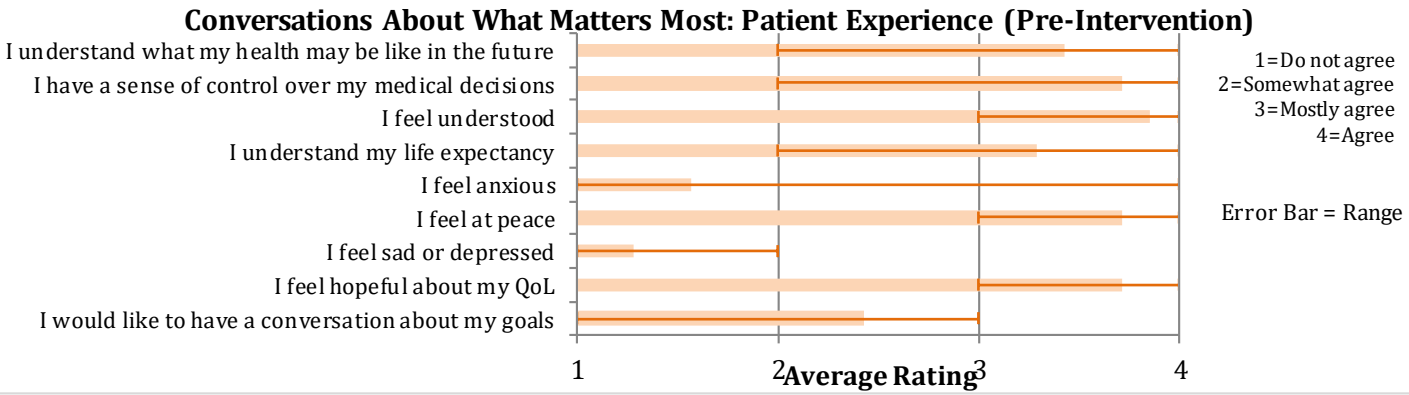
Patient Voice:
"These conversations are important. I know I am going to die… I like the idea of knowing what lies ahead"

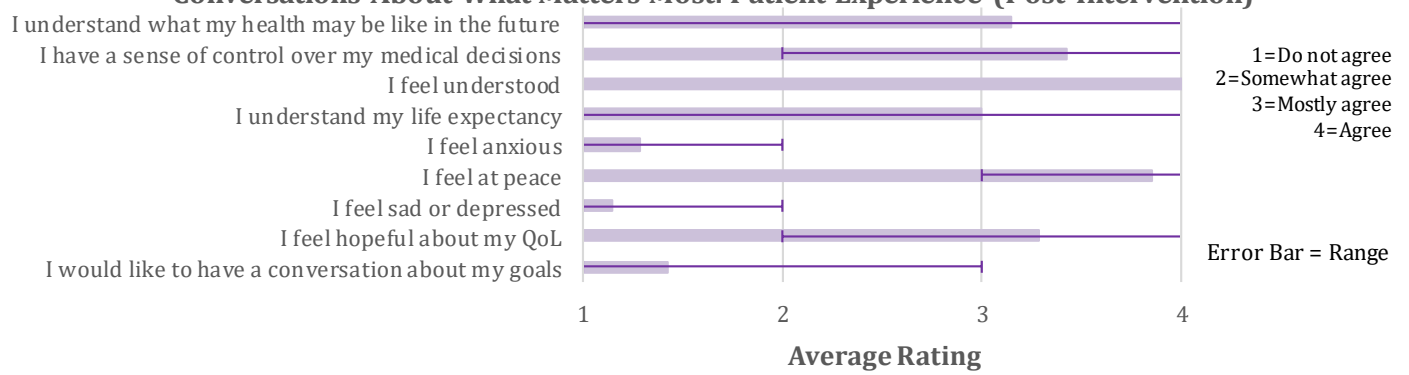
- Linnie, dialysis patient

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

Tools

Data Analysis:





Next Steps:

Based on Staff and Patient feedback:

1. Private spaces for intimate conversations
2. Simulated education for staff
3. Debriefing to staff on:
    a. Difficult conversations
    b. Caring for dying patients
4. Structured documentation process

Psychotherapy Prescriptions for Mental Health:
Encouraging Clients to Access Mental Health Services

Physician Lead: Dr. Michael Cooper

Location: Victoria ***Specialty:*** Psychiatry

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.

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 Psyychiatrists:

- 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:

Mental Health Therapy Recommendations

Psychotherapy Recommendations

Name: Date:

Family Physician or Preferred Walk-in Clinic:

Presenting Concerns:

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. Where 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. Psychotherapies, 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 day a Week
Exercise Time	10 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

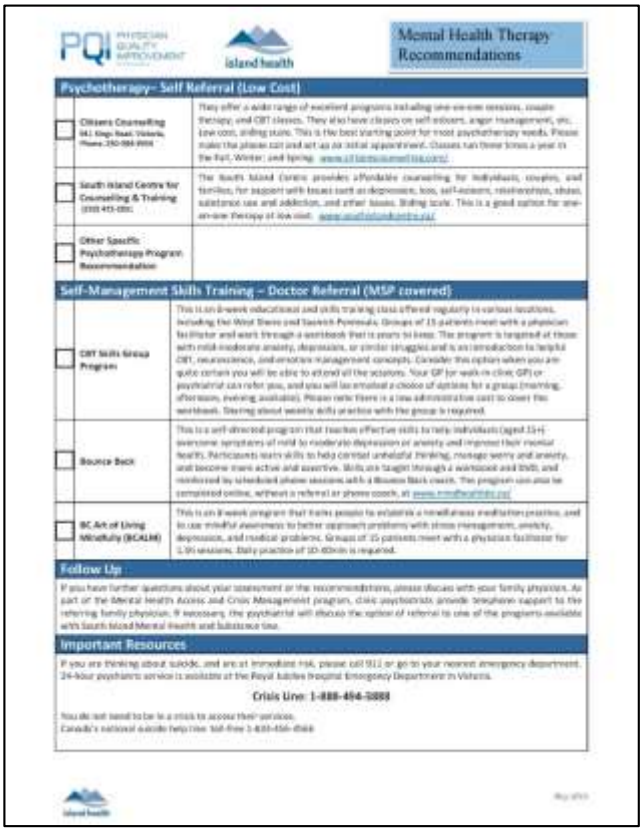
1. Find a quiet comfortable location, either sitting (preferably with your head supported) or lying down.
2. Check from toe to head for any muscle tension and let the muscles relax.
3. Shift your focus to your breathing. Notice the feeling of cool air as you breath in, and the sensation of your chest 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.
4. Focus on the sensations you are experiencing. "In the moment" with an attitude of non-judgmental curiosity. Inevitably, your attention will wander away from breathing or sensations. Don't worry. There's no need to block or eliminate thinking. When you get around to noticing your mind wandering—in a few seconds, a minute, five minutes—just gently return your attention to breathing.

Social Interaction	At least 1-3x/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 and communication.

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 print and choose ones that fit your needs.
☐	Anxiety BC	www.anxietybc.com/ They also have an app for smart phones called MindShift
☐	Therapeutic Lifestyle Change	This Society Stephen Ilardi has a lot of helpful information about exercising, social activities and other lifestyle changes to combat depression and anxiety.
☐	Mindfulness	www.uofmhealth.org/mindful Easy to follow guide to mindfulness techniques.
☐	Other Recommended Resource	



Mental Health Therapy Recommendations

Psychotherapy– Self Referral (Low Cost)

☐ Citizens Counselling 941 Kings Road, Victoria, Phone: 250-386-6906	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.citizensmentalhealth.org/
☐ South Island Centre for Counselling & Training (250) 475-0351	The South Island Centre provides affordable counselling 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/
☐ 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 walk-in clinic GP) or psychiatrist can refer you, and you will be emailed a choice of options for a group (morning, afternoon, evening available). Please note there is a one administrative cost to cover the workbook. Sharing about weekly skills practice with the 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.cmha.bc.ca/
☐ BC Art of Living Mindfully (BCALM)	This is an 8-week program that helps 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 10-40min is required.

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, crisis 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

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

Conclusions:

- 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

Anesthesia Block Room:
Using Parallel Processing to Improve Operating Room Efficiency

Physician Lead: Dr. Gus Chan

Location: Victoria ***Specialty:*** Anesthesiology

Background:

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

Problem:

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

Aim of Project:

- 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

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."

Change Idea:

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

PDSA Cycle:

Remodelling

Plan: How can parallel processing provide efficiency?

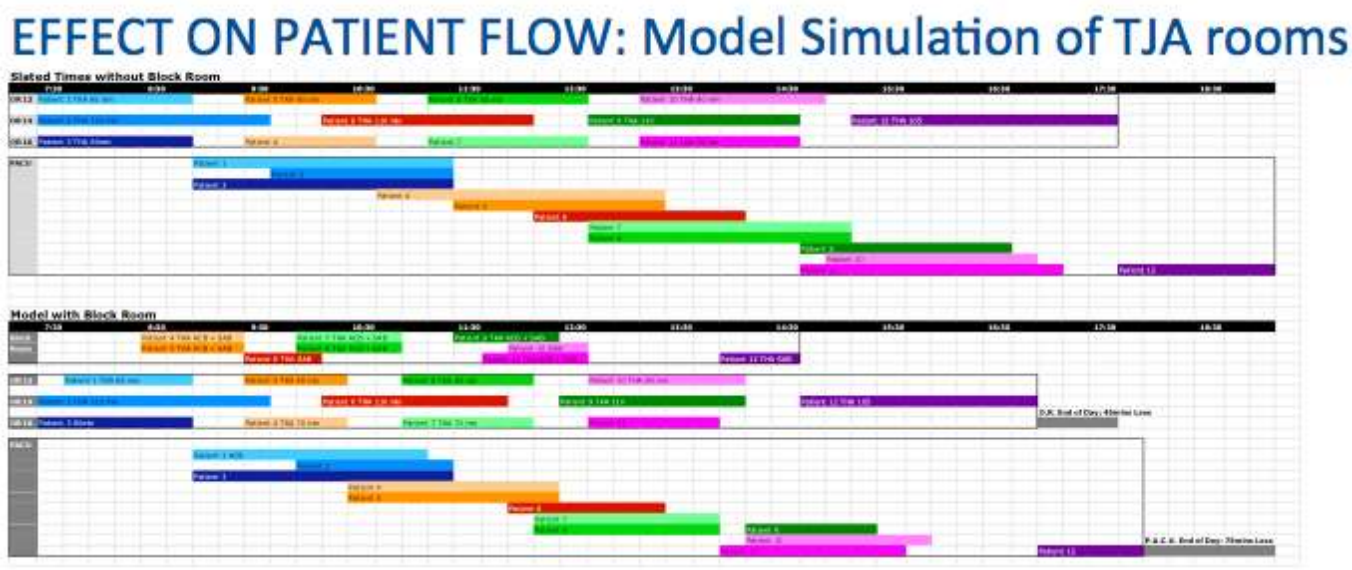
Do: Collect Data on Anesthesia Controlled Time in OR and spinal resolution time in PACU

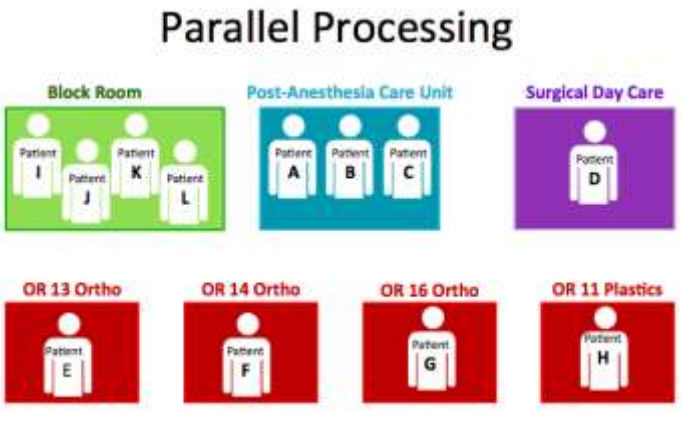
Study: Analyze Data

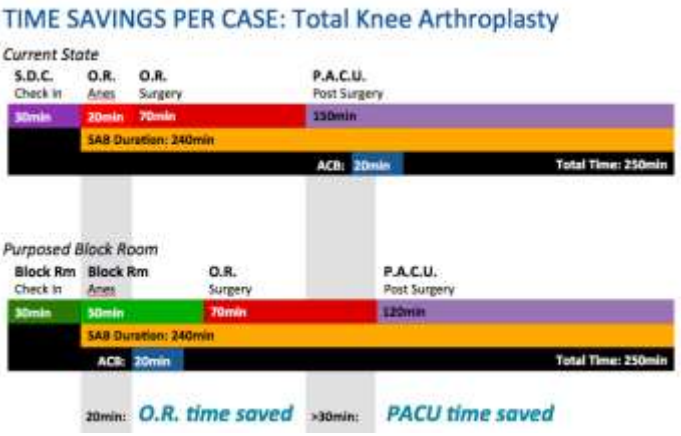
Act: Design model of time usage in OR/PACU with parallel processing in clock room

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







Conclusions:

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

STEP UP for First Episode Psychosis (FEP):

Medical Orders for Scope of Treatment in South Island Critical Care Units

Physician Lead: Dr. Daniel Boston

Location: Victoria ***Specialty:*** Psychiatry

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:

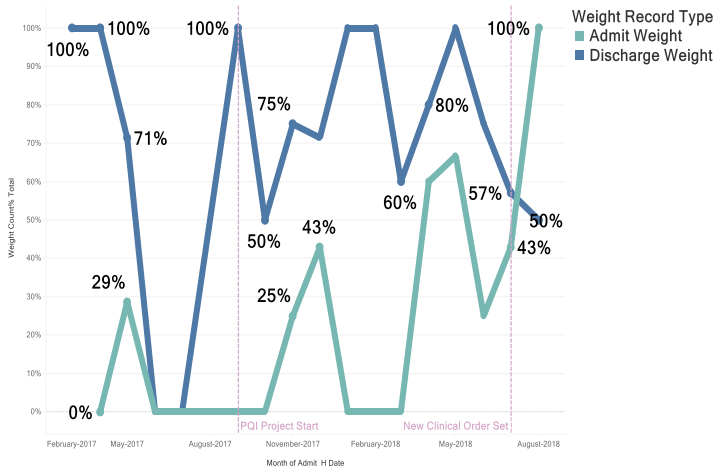
- Review relevant Canadian guidelines and provincial EPI standards
- Engage clinical team in improvement
- Engage patients and family in improvement
- Target cultural beliefs around medications of staff
- Develop and implement a clinical order set

Patient Voice:

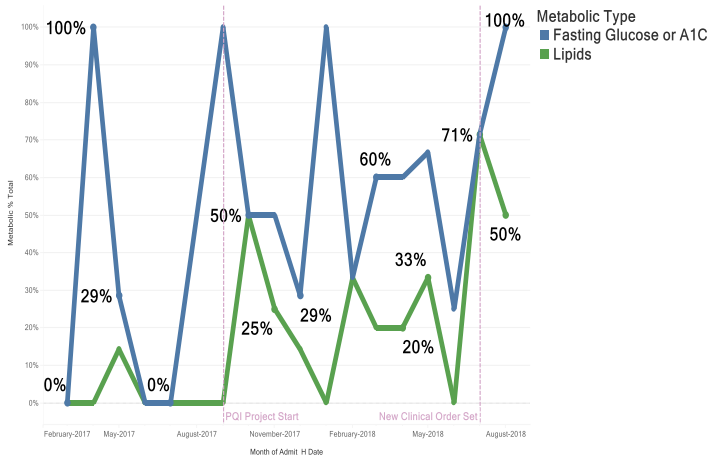
Patient and parent focus groups were held August 22nd and 23rd, 2018. Patients described their experience with medications as turbulent due to side effects. Parents felt that medications varied by doctor and unit and were switched abruptly without adequate explanation. Concerns regarding physical health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

Data Analysis:

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.