

PROBLEM

Many children and youth are identified as needing a pediatric assessment by schools. In Nanaimo some children and their families live in marginalized circumstances and have difficulty accessing services through the traditional physician referral process. As such, these children and their families have difficulty accessing pediatric care.

1. **What is the impact on the child, their families and the schools when they cannot access pediatric services?**
2. **Is there a different model of care that can improve access and support that is different than the traditional model of referral practice?**

AIM STATEMENT

Within 6 months, 100% of children who fit the project criteria will be identified and referred for school-based pediatric consults through a standardized process.

CHANGE IDEA

For children and their families who are not attached to a family physician, are underserved, or are living in marginalized circumstances and cannot access pediatric services through the standard referral pathway:

1. To develop and trial standardized processes at Georgia Avenue Elementary School for:
 - a. Identification of children who need pediatric assessment and support.
 - b. Obtaining parent/guardian consent for referral/assessment.
 - c. Referral of children to pediatric services.
2. To use these tools to evaluate the outcome of the assessments.

PROJECT TEAM

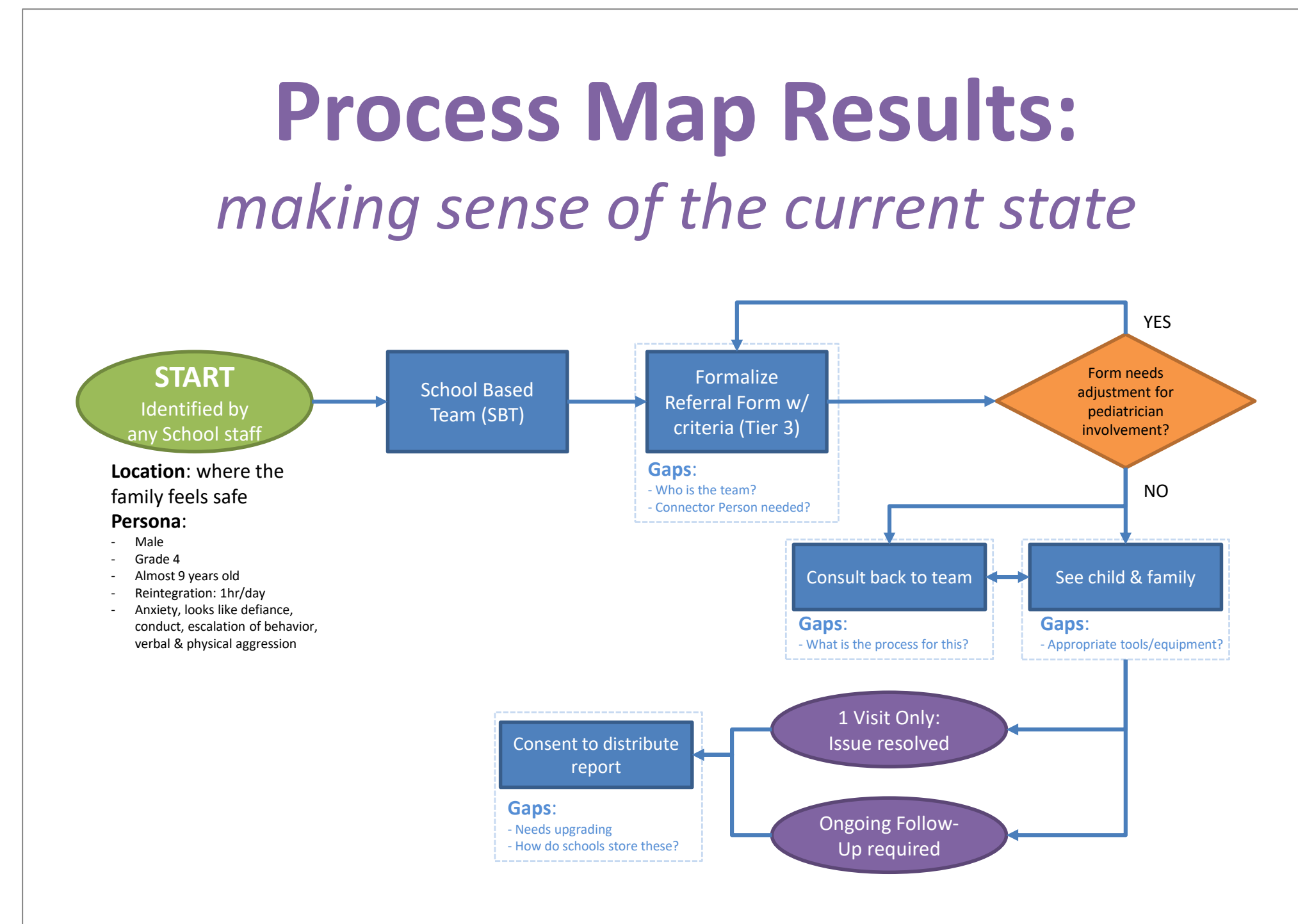
PQI Physician Lead: Dr. Wilma Arruda

Project Participants:

- **Cindi Ashbee** (CYC Georgia Avenue),
- **Claudio Aguilera** (Manager TLAFCCHC),
- **Bob Eslinger** (A Superintendent SD 68),
- **Deb Chaplain** (Director CYMH IH),
- **Jan Tatlock** (Director PH),
- **Erin Kenning** (CC PH Nanaimo),
- **Kirstin Funke Robinson** (SD 68 Psychologist),
- **Lynn Brown** (SW, SD 68)
- **Chelsea Wakelyn** (PQI Coordinator)
- **Curtis Bilson** (PQI Data Analyst)

PDSA Cycles

PDSA 1: Mapping ideal process with project team



PDSA 2: Creating/distributing new Consent & Referral Forms

Physician Quality Improvement Participant Consent Form

STUDENT REFERRAL FORM FOR ON-SITE PEDIATRIC CONSULTATION

DATA ANALYSIS

Referral criteria were developed in collaboration with school district representatives. Data was collected through the development and use of a standardized referral tool that captures:

- D.O.B.
- Health system interactions (e.i. GP yes/no)
- Previous interventions
- Psychosocial barriers (poverty, transience etc.)

FINDINGS

- **80%** of children referred had no GP or were unable to access a GP
- **80%** of referrals resulted in a face-to-face pediatric assessment.
- **40%** of children seen were referred for other health services



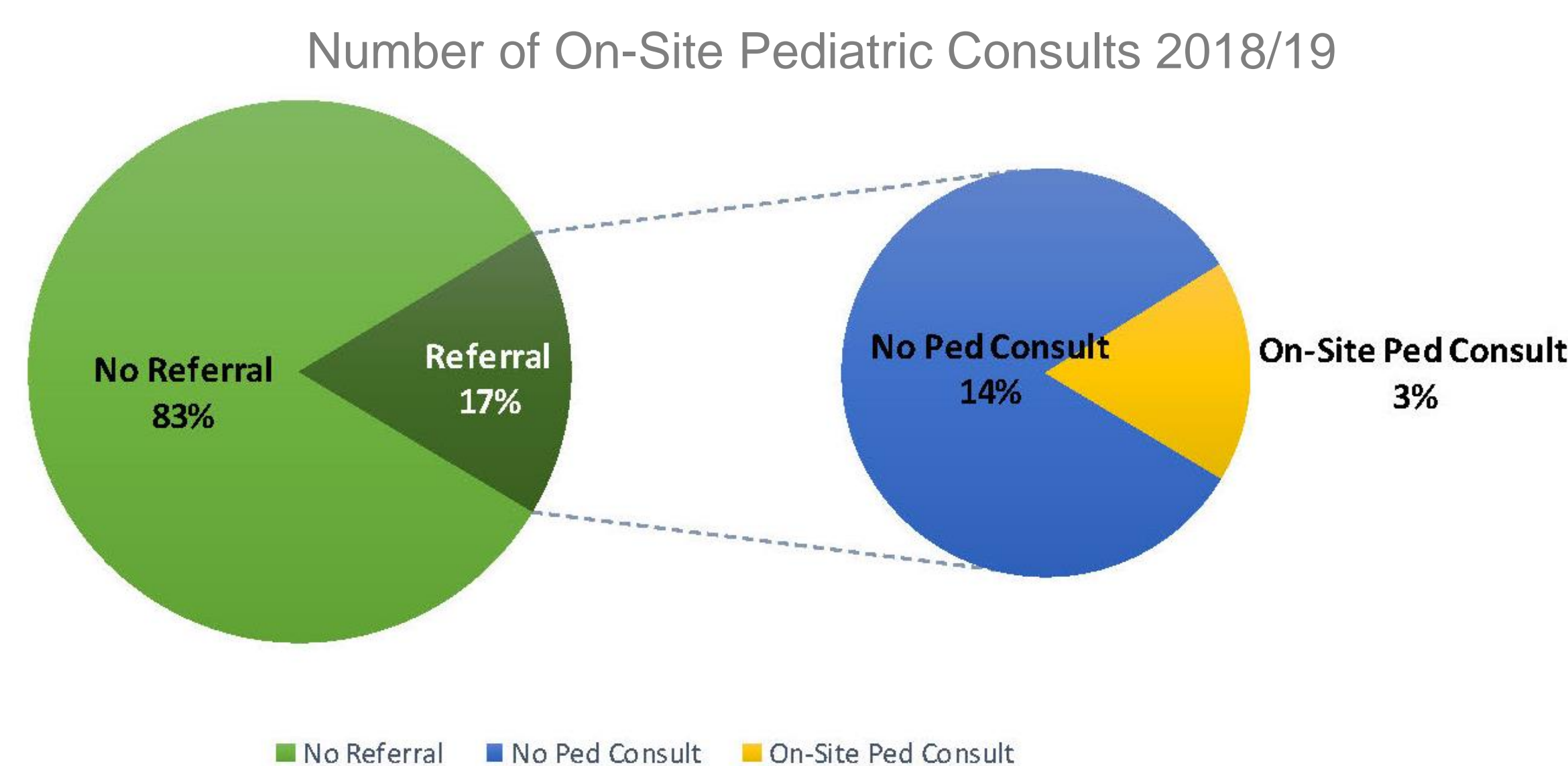
CONCLUSION

Due to their life circumstances some children do not receive pediatric assessment when it is needed. These are children who are not well represented in MoH data and should be seen as “invisible” by the health care system. This project is not yet complete but early findings suggest that an alternative model of care more appropriately supports these children’s health care needs and, as such, will support the health and wellbeing of the child in the family structure.

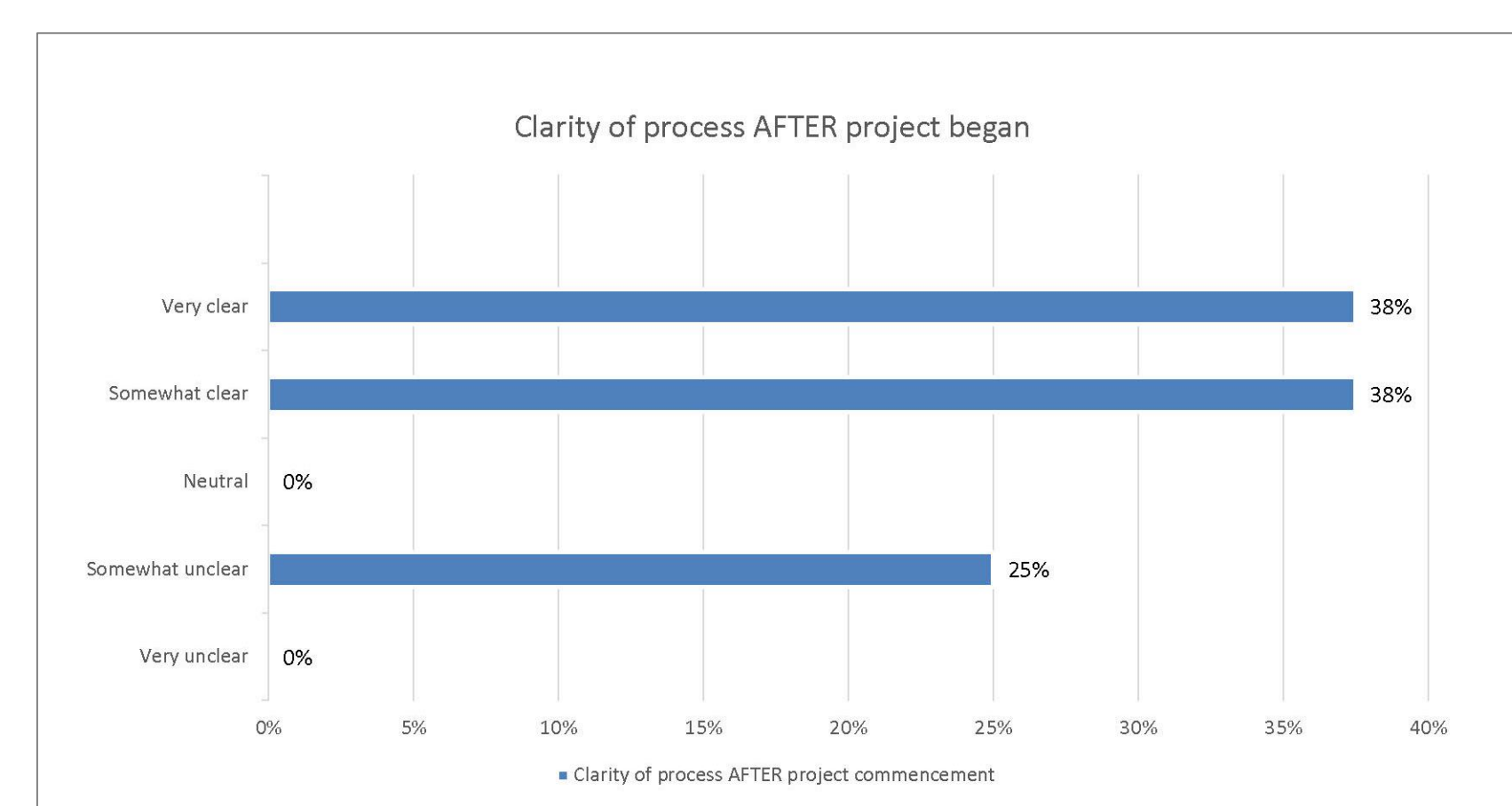
PROJECT SPREAD

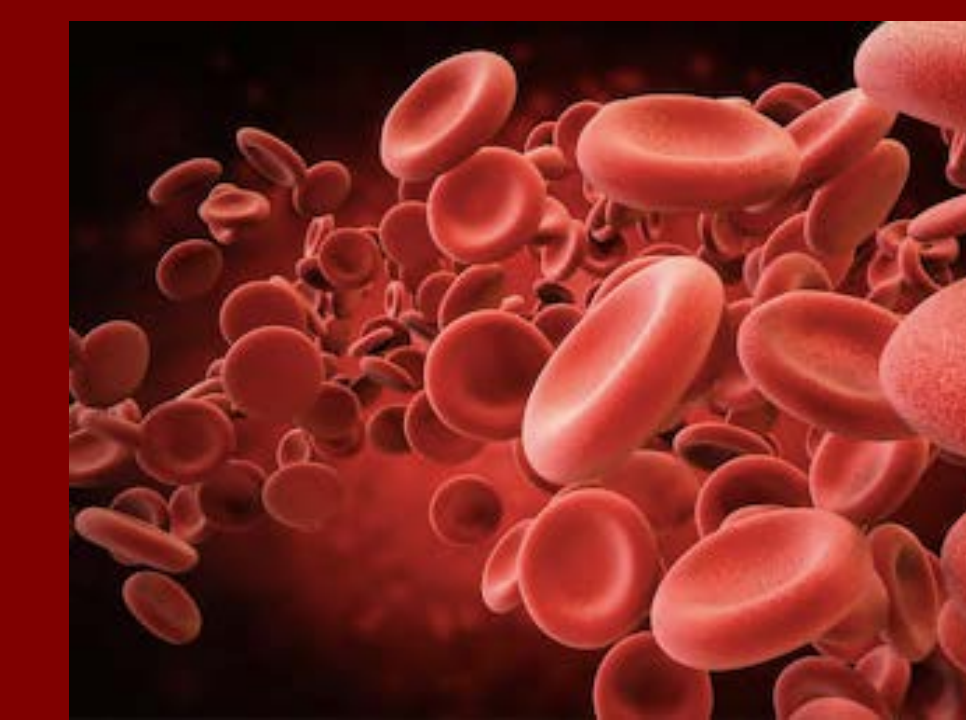
- Standardized package for interested schools. Implementing “one piece flow” process of referral through to assessment using one form that doubles as a data collection tool.
- Recording and analyzing assessment outcomes to support project’s value.
- Presentation to school district and health authority leadership to gain endorsement for program spread.

PDSA 3: School District baseline data collection



PDSA 4: Collecting feedback from school-based team





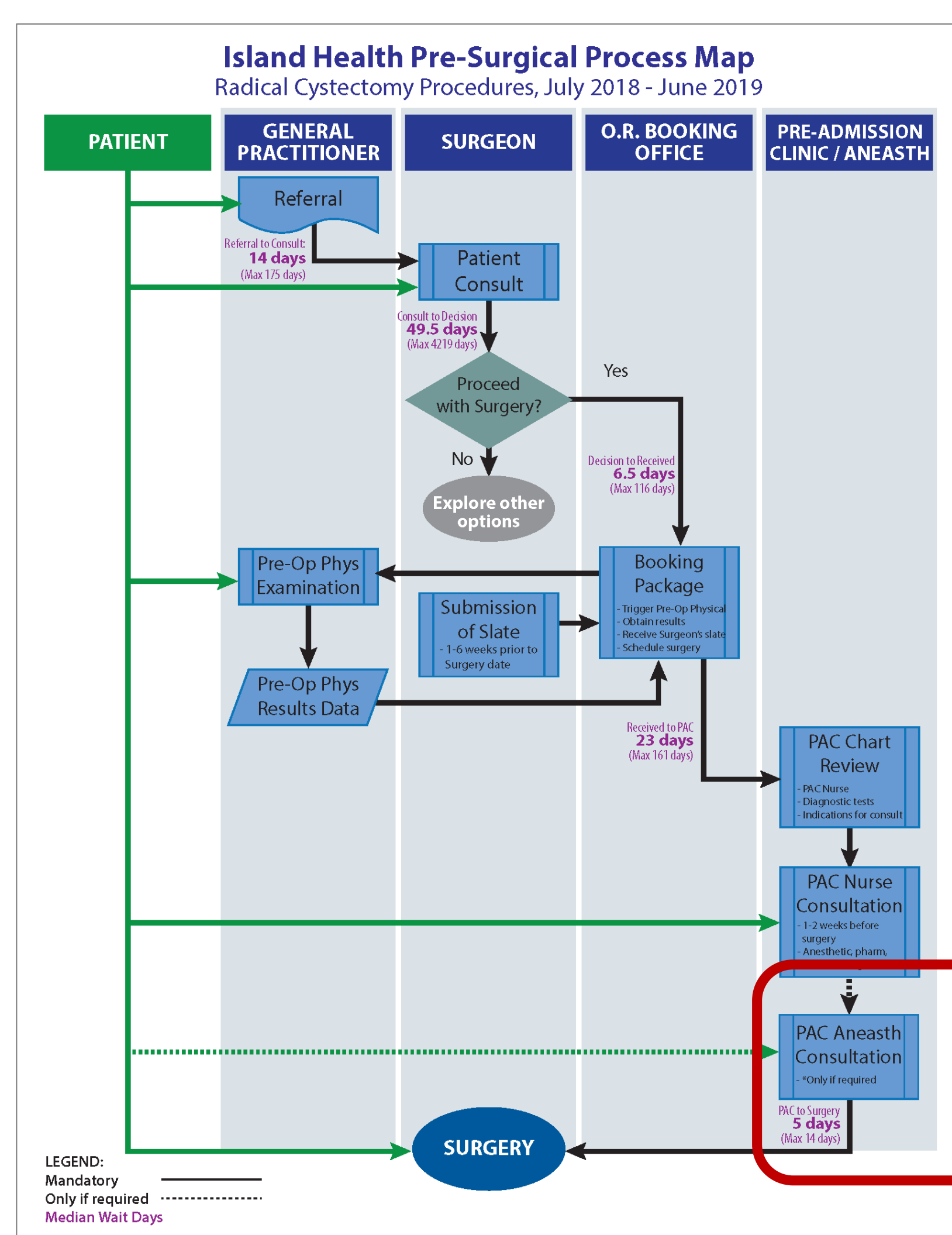
BACKGROUND

Patient Blood Management (PBM) is an evidence-based multidisciplinary approach to optimizing the care of patients who might need a transfusion. It is based on 3 pillars of care:

1. Optimizing Erythropoiesis
2. Minimizing blood loss and bleeding
3. Harnessing and optimizing physiologic reserve

PROCESS MAP

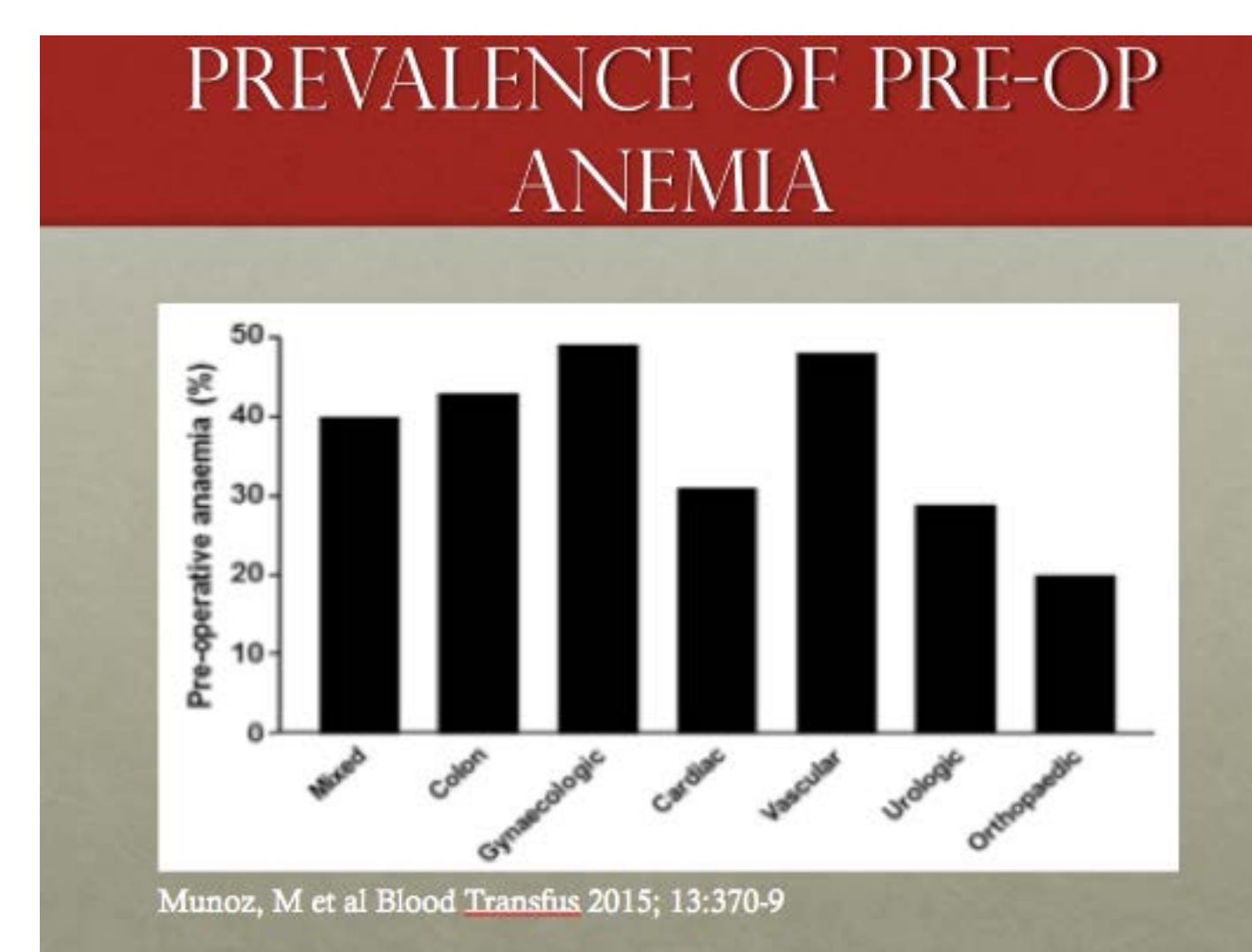
The project team developed a Process Map of Radical Cystectomy Procedures. This map shows where the patient has direct contact with the health care system, visualizing the steps prior to the surgical procedure, and the current average time durations for each of these steps.



It was shown that patients are currently being identified at the Pre-Admission Clinic (PAC) an average of 5 days pre-operatively. This does not allow sufficient time for the diagnosis and treatment of anemia.

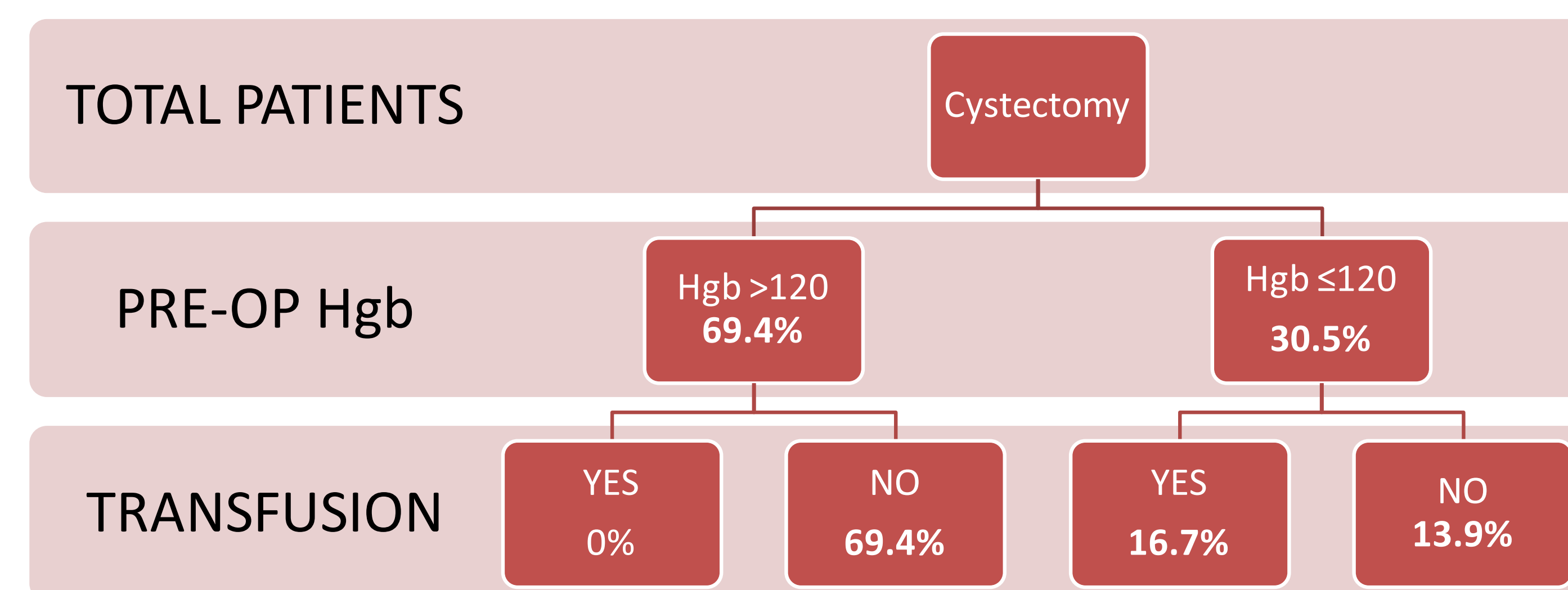
PROBLEM

Pre-operative anemia increases risk of transfusion in high blood loss surgeries. Transfusion and anemia independently increase risk of morbidity and mortality. Patients undergoing cystectomies are at risk of pre-op anemia, intra-operative blood loss, and transfusion. In Victoria, there is no program in place for identifying and treating patients pre-operatively.



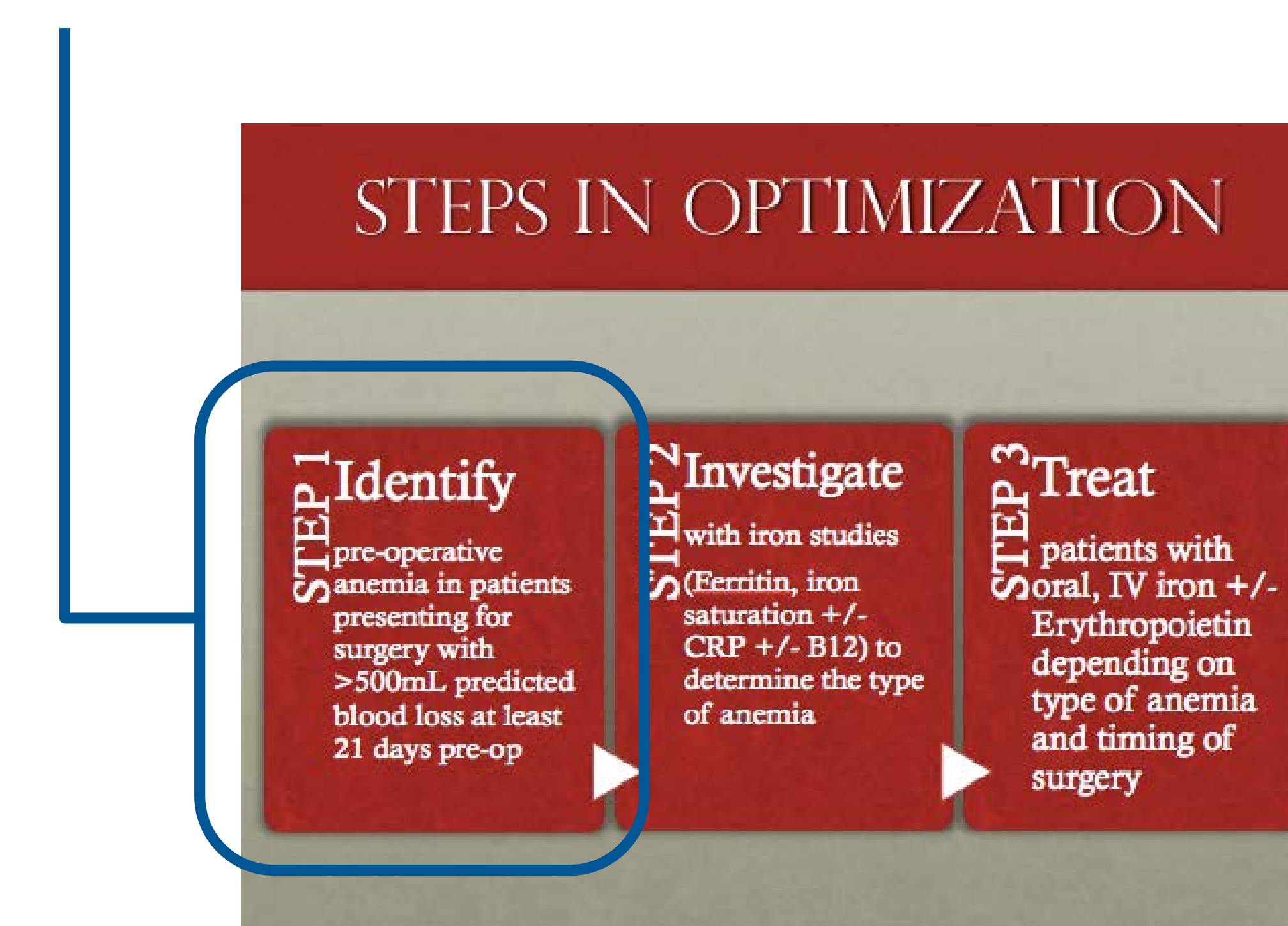
RESULTS SO FAR

Looking at patients who underwent radical cystectomies from July 2018 to June 2019 there was a high incidence of pre-operative anemia. All patients who received transfusions had a starting Hemoglobin of less than 120.



AIM STATEMENT

To create a system that permits identification of all anemic patients in Victoria scheduled for radical cystectomy with at least 21 days to optimize pre-operatively, by March 2020.



PROJECT TEAM

Dr. Julie Paget – Project Lead

Project Participants:

- Dr. Tom Ruta – Department Head and Medical Director Department of Anesthesiology
- Dr. John Kinahan – Urologist
- Dr. Mike Metcalfe – Urologist
- Dr. John Galbraith, Medical Microbiologist, PQI Mentor
- Dr. Brian Berry, Hematopathologist
- Dr. Jesse Pewarchuk – Internist, Co-founder Revive Clinic
- Curtis Bilson, PQI Data Analyst
- Chelsea Wakelyn, PQI Project Coordinator
- Jason Price, PACU/SDC RJH Manager
- Rachel Wilson, Clinical Nurse Educator

PROJECT SPREAD

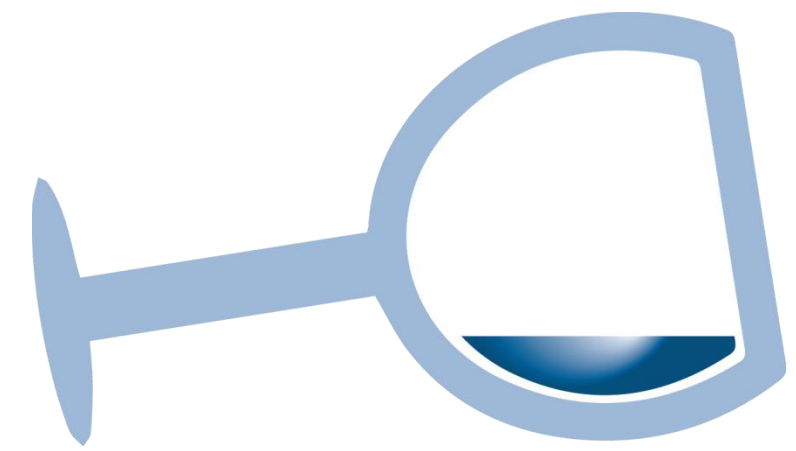
Educational events have been held for the Department of Anesthesiology, Divisions of Family Practice and the South Island Surgical Services Physician Advisory. A pre-operative anemia multidisciplinary event is planned for late fall.

NEXT STEPS

The ultimate goal of this project is to create a system-wide pre-operative hemoglobin optimization program for South Island. The initial challenge has been in identifying patients with sufficient time for optimization while minimizing workload impacts. The first step is to create a model to identify, investigate and treat cystectomy patients and subsequently apply this model to all high risk surgical patients.

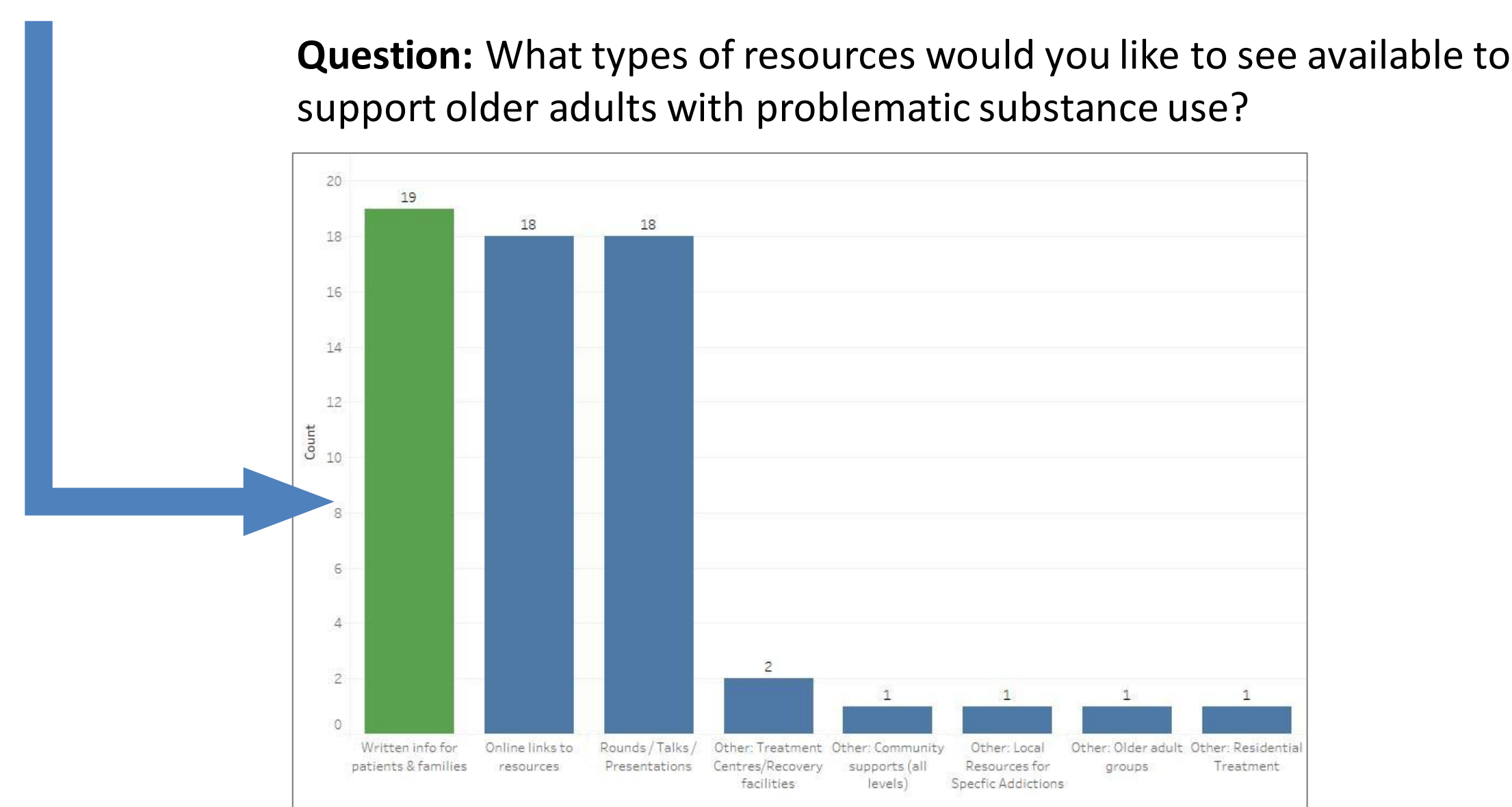
BACKGROUND

- Older adults experiencing problematic alcohol use can be very successful in making changes to unhealthy drinking, however few supports exist, in Island Health or elsewhere, to address the unique needs of this population
- A key recommendation in the 2018 report by the Canadian Centre on Substance Use “Improving Quality of Life: Substance Use and Aging” calls for a greater awareness of the issue among healthcare providers and caregivers
- GSS outreach teams are in a unique position to understand the complexities of this issue



STAFF SURVEY

Based on survey feedback from GSS clinicians which identified a resource need of ‘written information for patients and families’

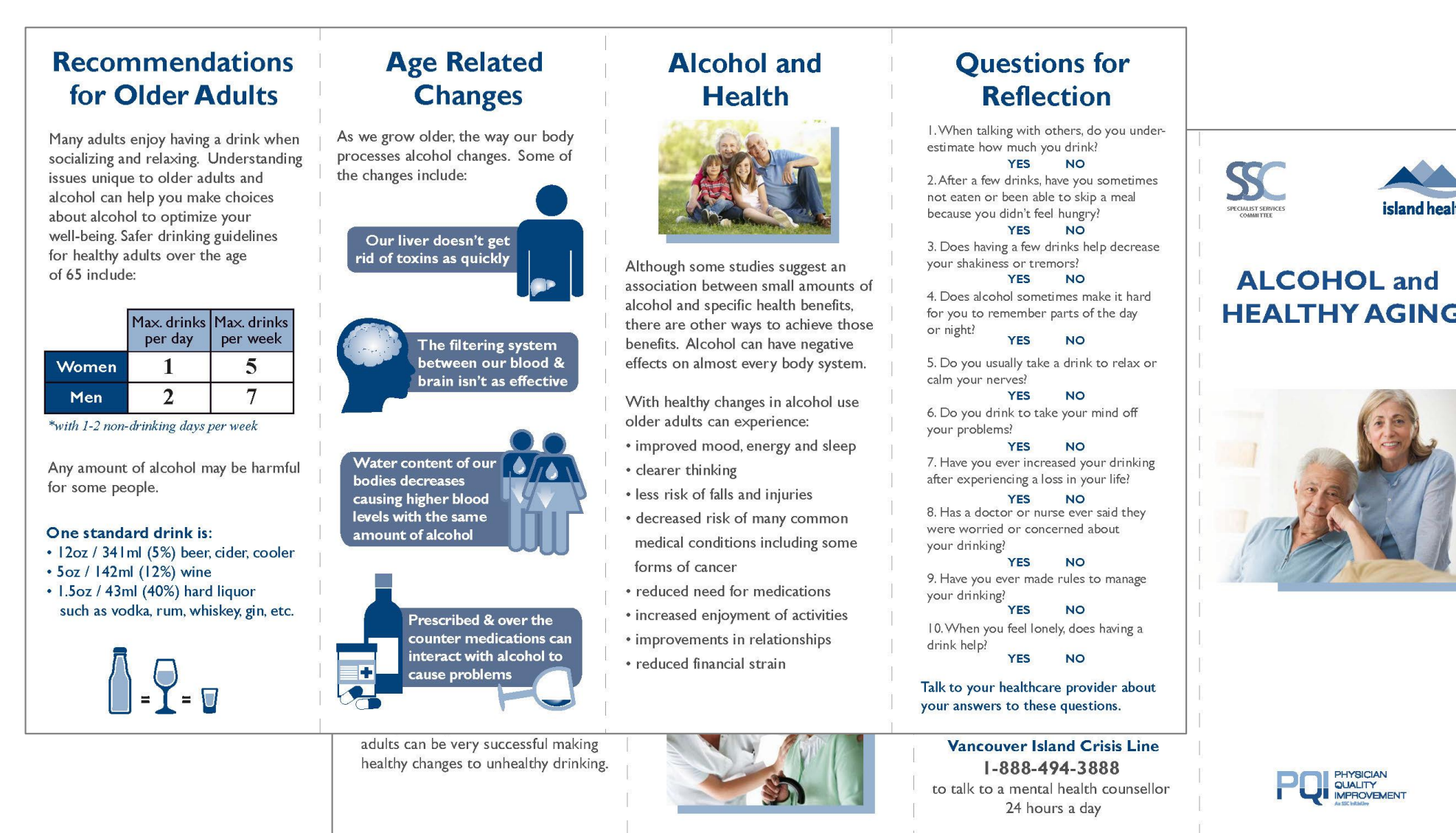


PROBLEM

- Older adults inconsistently receive information to improve understanding and support change related to problematic alcohol or other substance use
- Due to accessibility and prevalence of use, as well as biologic effects, alcohol is the psychoactive substance producing greatest risk and range of harms among older adults
- Harms related to problematic alcohol use are far-reaching and impact the individual, their loved ones, the healthcare system and society as a whole
- BC is the province with the highest rate of alcohol related hospitalizations and older adults have higher rates than any other age group

CHANGE IDEA

Develop a pamphlet, with evidence informed content, to support clinicians, patients and their loved ones in beginning to address problematic alcohol use



AIM STATEMENT

- Increase familiarity of patients, families and care providers within Geriatric Specialty Services (GSS) Outreach, with information specific to older adults experiencing problematic alcohol use
- by 90%
- by August 2019.

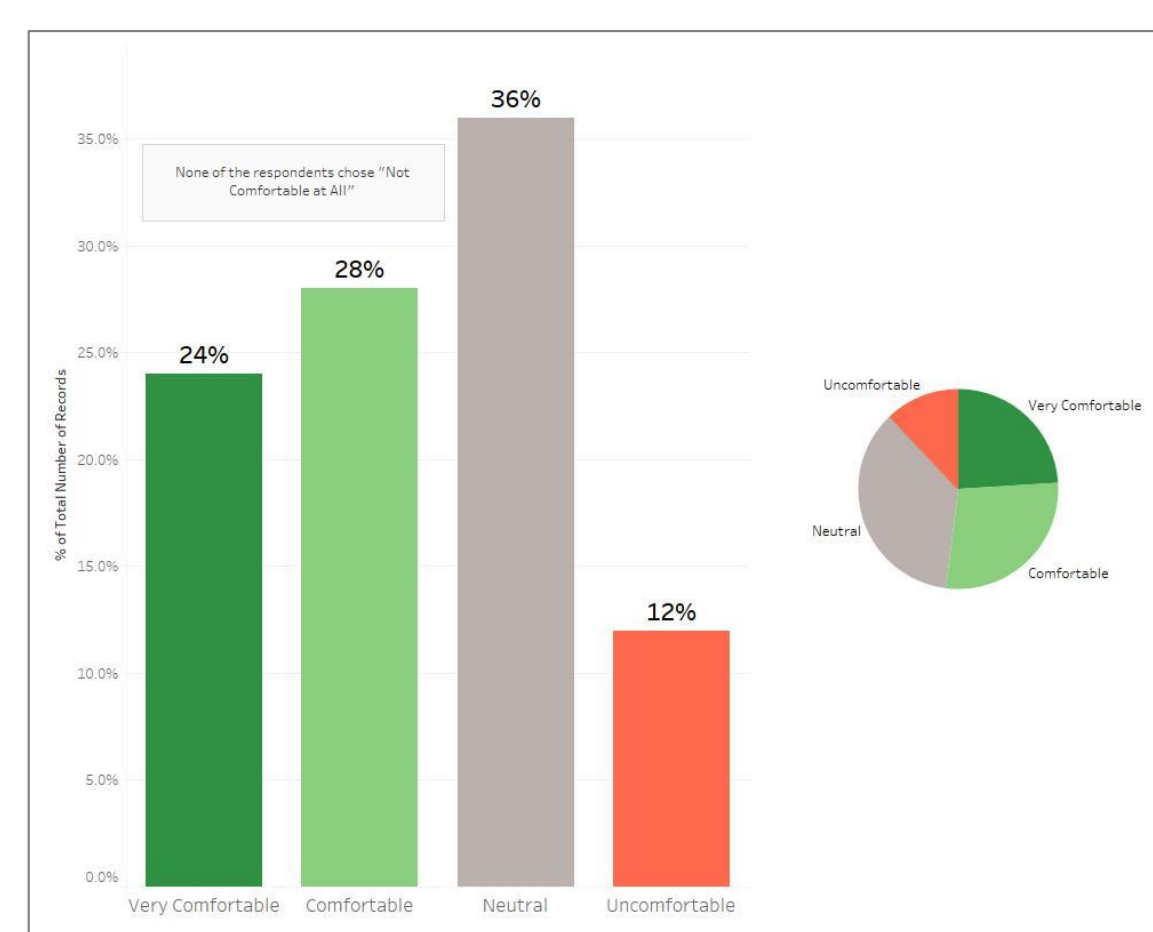
PDSA CYCLES

- Survey of team needs
- Written resources review (other pamphlets, CCSU summary and key information resources)
- Initial pamphlet **draft 1** structured to support approach of Screening, Brief Intervention and Referral to Treatment (SBIRT*) plus harm reduction tips
- GSS team working group meeting for summary of issues, initial pamphlet review, brainstorming content, review of local resource experience
- Revision **draft 2** (add SMAST-G screening tool, delete local resources as they were felt to not be suitable to specific needs of older adults, change info sequence)
- Pamphlet feedback patient voice and RAAC team, Umbrella
- Revision **draft 3** (increased focus of content on health impacts)
- Pamphlet feedback patient voice
- Revision **draft 4** (reintroduction of local resource list, after further discussions of how to better meet specific needs of older adults in some of those settings)
- GSS outreach family physician feedback
- Revision **draft 5** (language and wording modifications)
- Pamphlet feedback patient voice (independent living setting and community)
- Pamphlet **draft 6** (change panel order)
- Distribution with informal and formal orientation to pamphlet content as needed

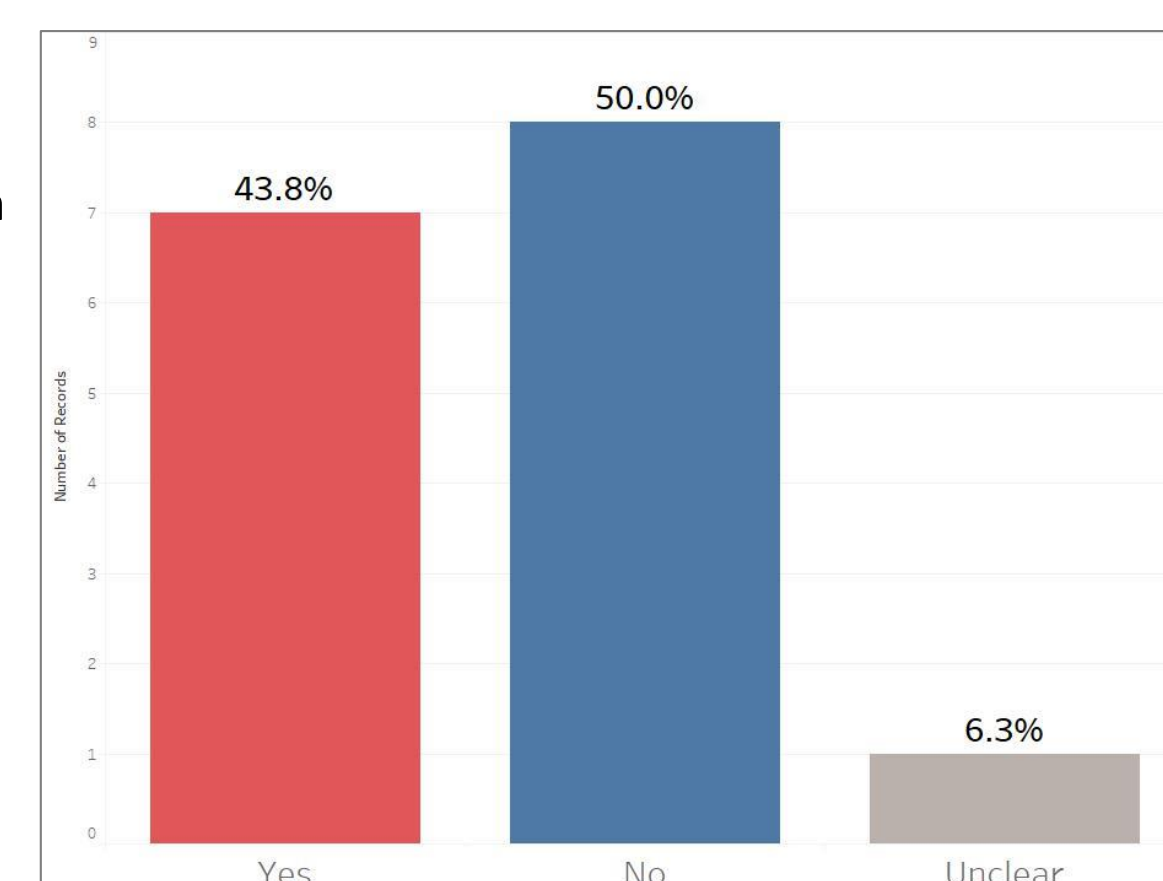
*SBIRT- an approach shown to be effective and cost-effective in reducing harmful levels of drinking and alcohol-related harm for patients in primary care and emergency room settings

MEASURES and DATA ANALYSIS

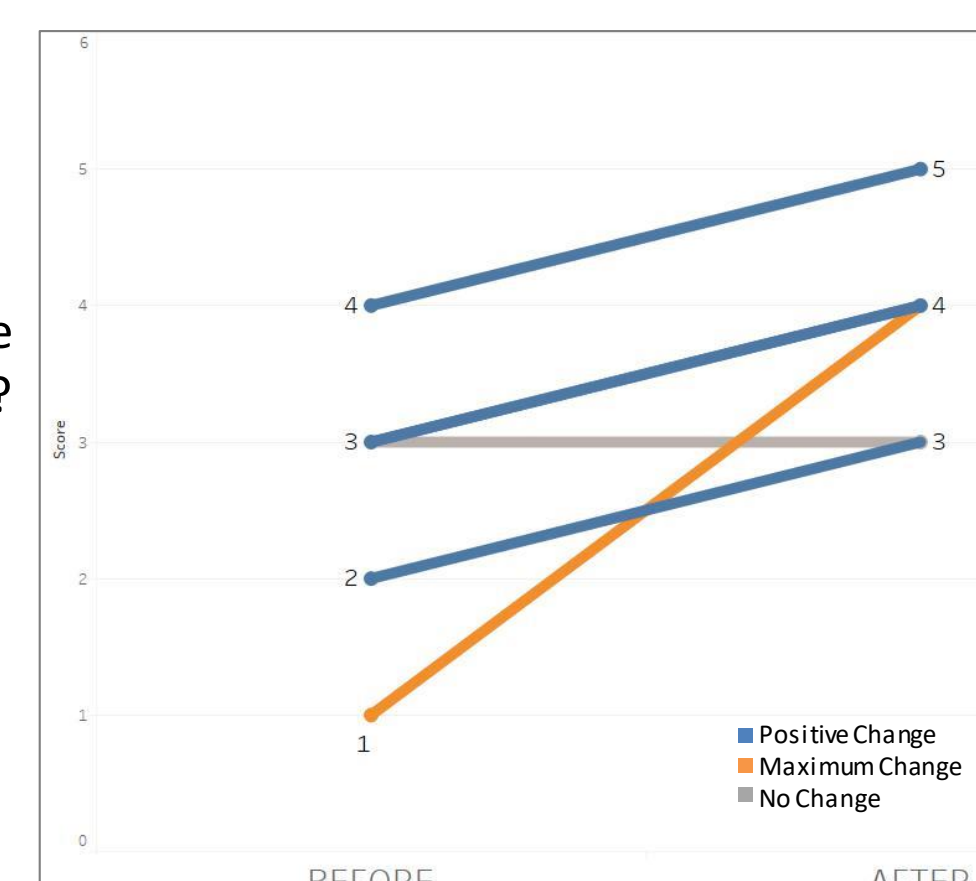
PRE-CHANGE SURVEY
Question: How comfortable are you providing specific support for older adults who use substances?
n=25
November 2018
Staff/Participant Survey
Data Analysis: Curtis Bilson



PRE-CHANGE PATIENT CHART REVIEW
Substance Use of Concern
n=16
August 2018
Patient/GSS Outreach
Data: PowerChart review (primary data collection)
Data Analysis: Curtis Bilson



PATIENT VOICE SURVEY
Comparison of score difference;
Question: On a scale of 1 to 10, how much did you know about alcohol and healthy aging (before and after reading the pamphlet)?
n=6
July 2019
Data: Responders
Data Analysis: Curtis Bilson



PROJECT TEAM

Project Lead: Dr. Joyce Coutts, Geriatric Specialty Services

Dr. Marilyn Malone, Sponsor/ Medical Director Seniors Strategy

Geriatric Specialty Services Outreach Teams:

Nurses, social workers, occupational therapists, family doctors, geriatric psychiatrists

Patient Voices:

Community members accessing Island Health Services, various sites

Rapid Access Addiction Clinic (RAAC) team:

Nurses, social program officers/ SPOs, medical students and residents

Umbrella workers (esp. Louise)

Amanda Chapman, Coordinator, Addiction Medicine Education & Forums/

Primary & Community Care Island Health

The PQI Team

“there is definitely a desire for the education”

“[the pamphlets] went like hot cakes”

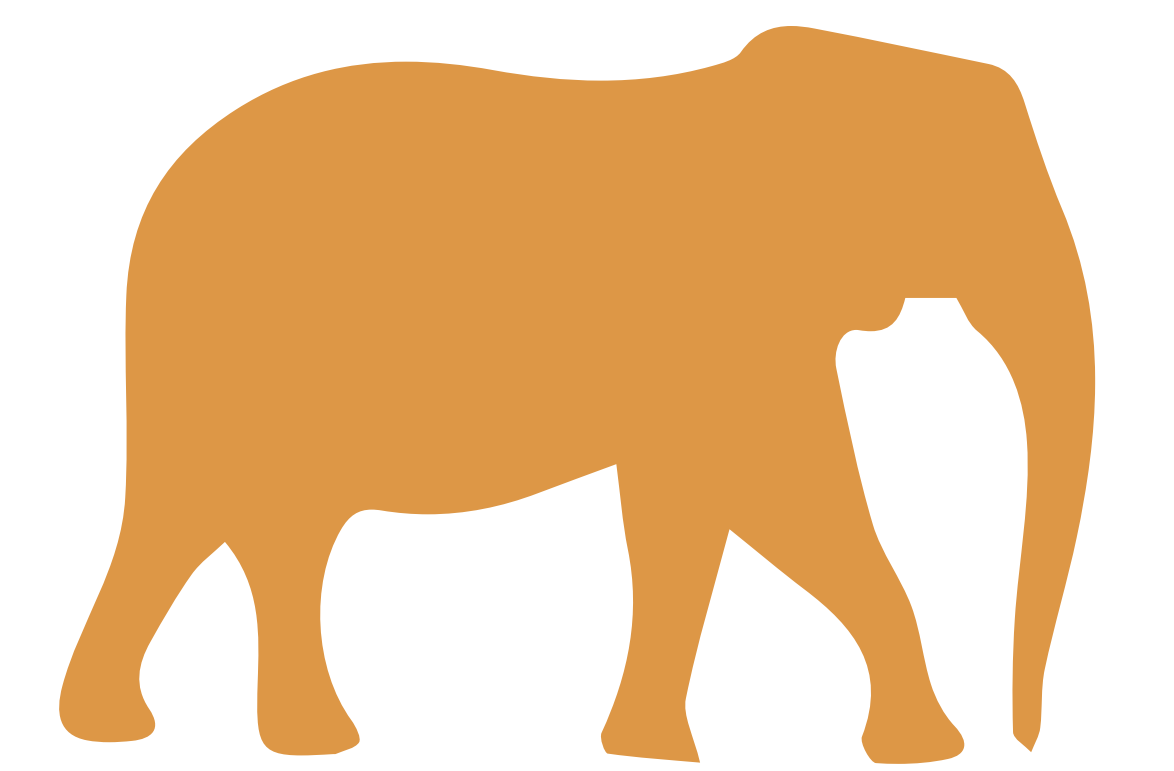
CONCLUSION

Improvements in quality of life and health outcomes result when older adults have the information and supports they need to make healthier choices about alcohol. There are many places within Island Health where older adults experiencing problematic substance use interface with the system of care and many opportunities for care providers to initiate conversations that can inspire healthy change. Having a tool to support conversations with patients about this issue is one step toward improving care for this vulnerable population.



GROWING the HERD

Improving 2 Year Old Immunization Rates at Victoria Health Unit



PROJECT TEAM

Dr. Dee Hoyano - Project Lead

Project Participants:

- Charlotte Brown, Public Health Nurse
- Morgan Fankboner, Public Health Nurse
- Tia Ndjalski, Coordinator, Public Health Nurse
- Kathy Palmer, Public Health Nurse
- Hilary Planden, Coordinator, Public Health Nurse
- Cathy Pyett, Administrative Coordinator
- Melinda Warren, Lead Administration, Victoria Health Unit
- Dr. Daisy Dulay, PQI Physician Advisor
- Dr. John Galbraith, PQI Physician Advisor
- Rosie Holmes, PQI Coordinator
- Curtis Bilson, PQI Data Analyst

BACKGROUND

- Immunizations rates for children on Vancouver Island fall well below provincial and national targets (95% coverage) and put individual children and communities at risk of disease outbreaks.
- 2 year old immunization coverage rates have not been improving over last several years and hover around 75-80% for South Vancouver Island

PROBLEM

Drops in immunization coverage have been noted after 12 months of age. This is likely multi-factorial including: increased family demands (return to work for mothers), bottlenecks in appointment availability, lack of consistent reminders or recall, misinformation or vaccine hesitancy.

AIM of PROJECT

To increase immunization coverage rates (all antigens) at 2 years of age for the Victoria health units by 10% by August 31, 2019.

PATIENT VOICE

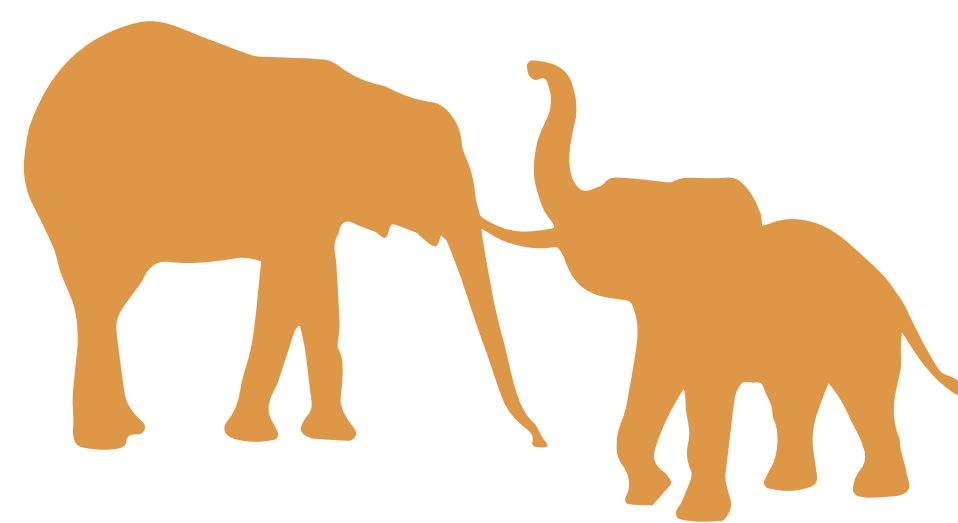
"Can't you just text me? My hair stylist and my car mechanic use texts for my appointments."



CHANGE IDEA

- Reminder system including email, text and other modalities (selfie booth)
- Standardized chart note for overdue patients to capture patient/family barriers to immunization
- Consistent recall system for overdue vaccinations

PDSA 1



Staff Focus Group:

- Qualitative data on current practices
- Barriers and Opportunities
- completed TRIZ exercise

PDSA 2

Project Data:

Data collection and analysis of under-immunized cohort

PDSA 3

QI Board Data Visualization:

Designed to recognize the work the staff have done

PDSA 4

Technology Reminders:

Email and text reminders for 18 month immunizations

PDSA 5

VHU Selfie Stand:

Visual backdrop for parents to take photo of child with

DATA ANALYSIS

• Immunization coverage is routinely collected in the public health information system, Panorama. However, administrative information such as appointment bookings, and no-shows are kept in separate systems.

• Most of the immunization push or pull factors are not captured by current systems and difficult to measure.

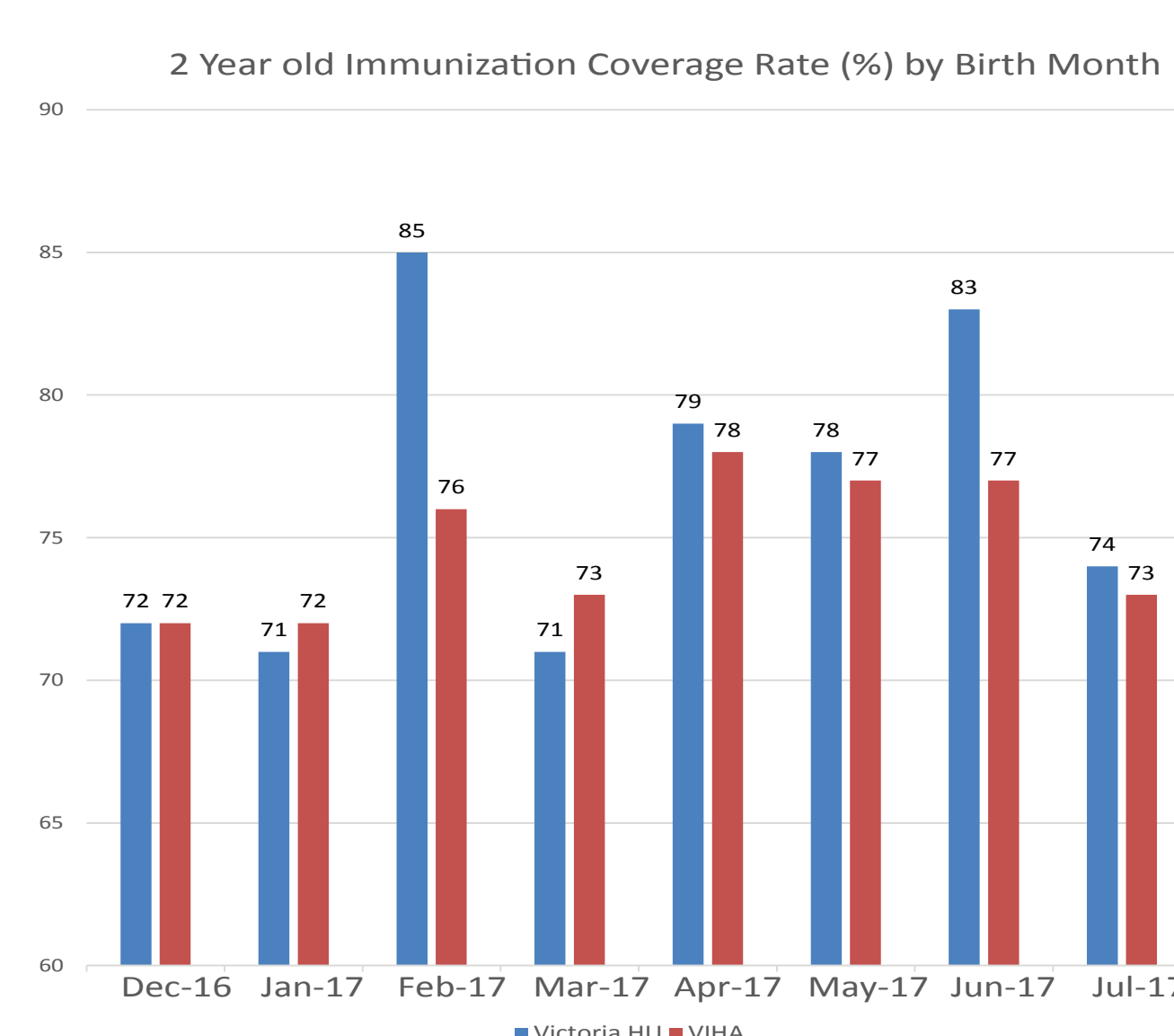


Image 1: Immunization coverage rates by birth month. Not consistently reaching the target of 86% yet.

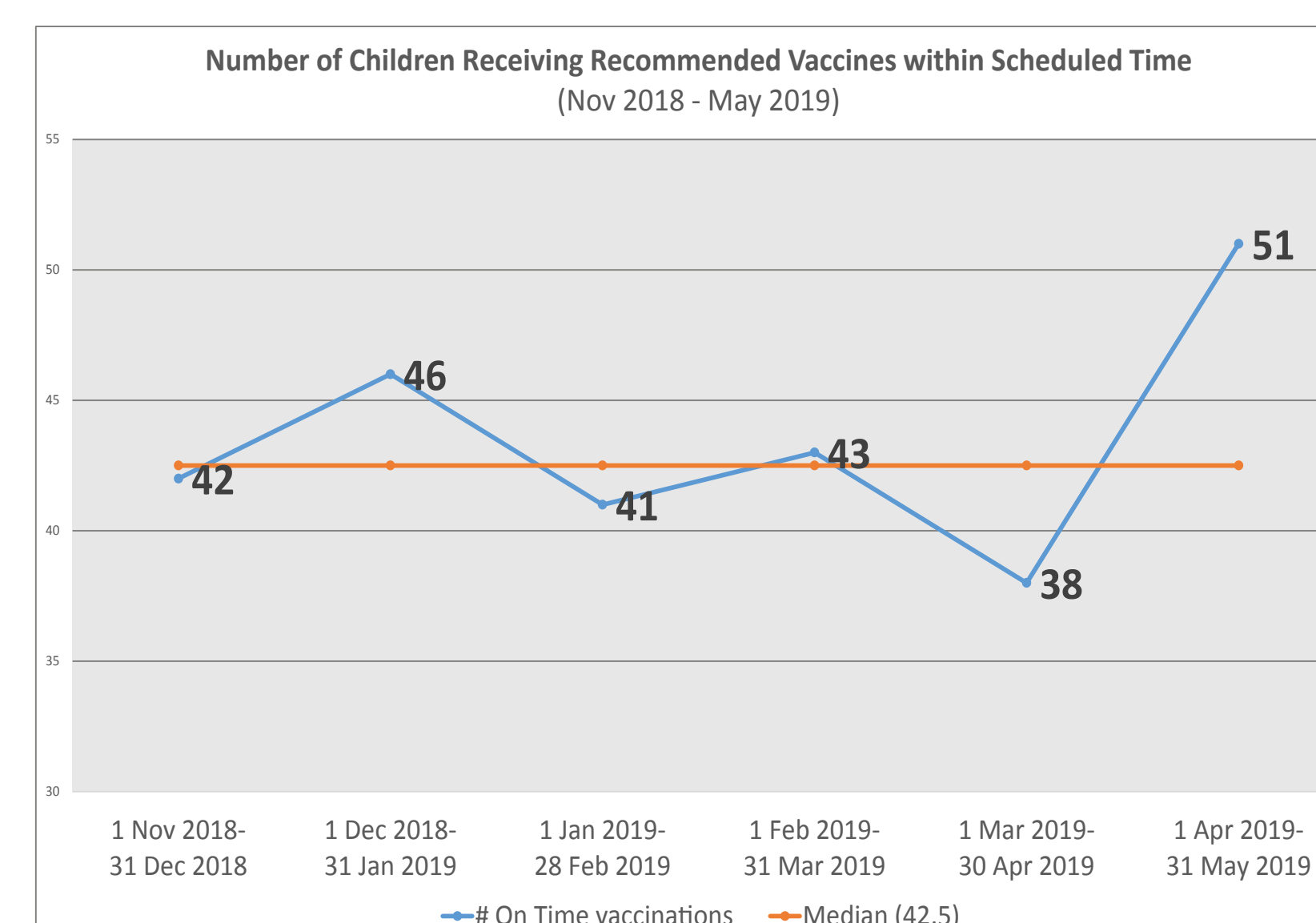


Image 2: Most children are receiving their vaccines on time, but the number varies month to month

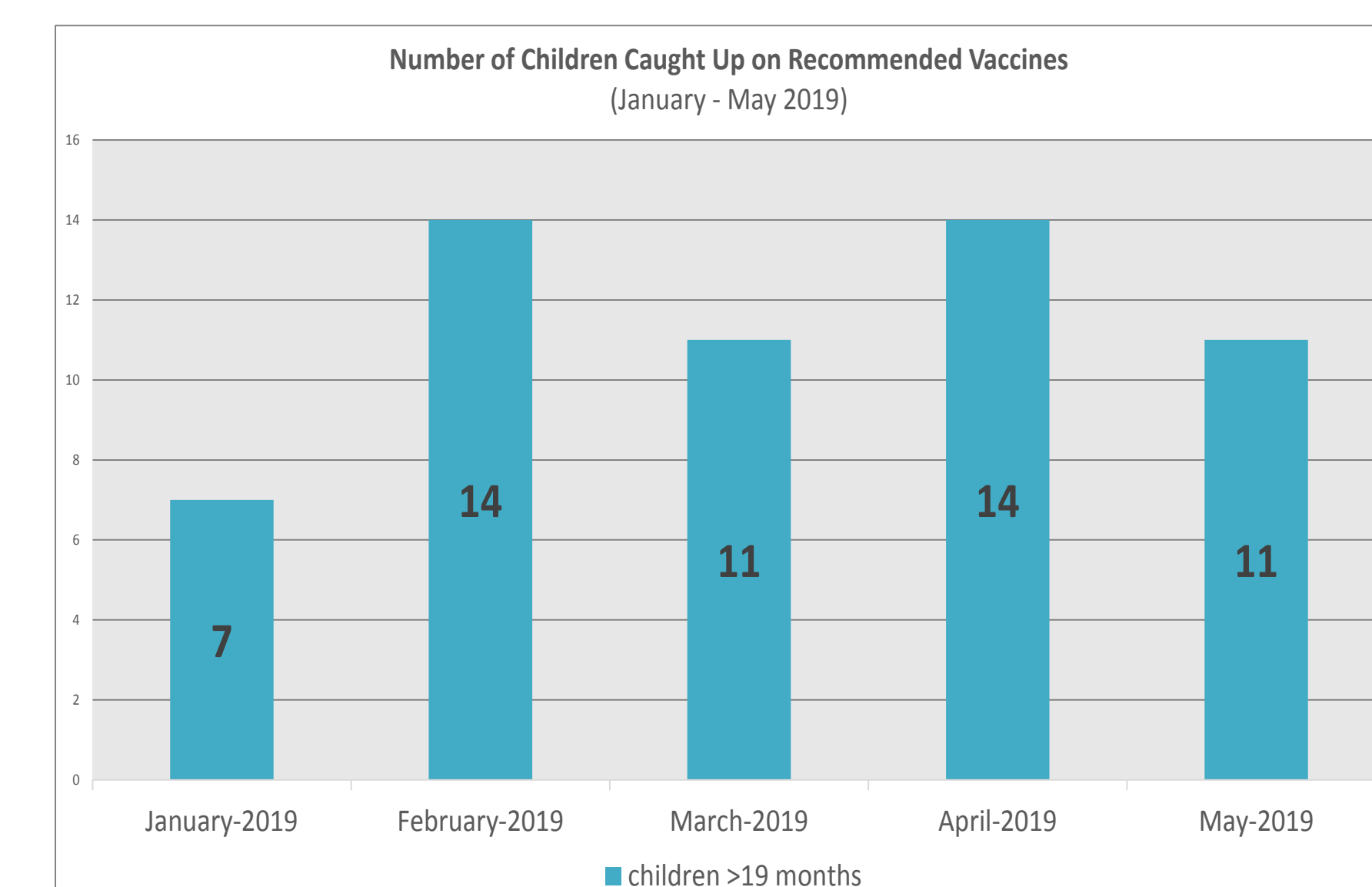


Image 3: Unsure why these children are getting caught up now. What pulled or pushed them into the health unit for vaccination?



FINDINGS

- Partial immunization contributes to most of the coverage gaps, not complete refusal of vaccination. This is an opportunity for action.
 - Current patient reminder systems are inadequate, rely on outdated technology, manual tasks and patient initiative
 - No consistent recall system is in place region-wide, staffing limitations and concern about patient-provider relationships are barriers
 - Patients are open to email and texting reminders, high acceptance rate
- Have not yet seen an impact on overall coverage rates

NEXT STEPS

- Email and text reminders are acceptable to patients. Need to monitor for impact on vaccination outcomes, as well as adapt implementation in the most streamlined manner in all health units
- Need to dedicate staff time to reminder & recall activities
- Explore feasibility of extending reminder system to younger cohort (at birth or 2 months of age)
- Adapt implementation for admin staff by minimizing data collection and input
- Explore other ways to celebrate families that vaccinate their children and motivate them to make this the social norm
- Recall activities should be standardized into program deliverables and monitoring so that it is not at risk with shifts in resource allocation





project team

Project Leader - Dr. J. Kouwenberg

Project Participants:

- Rosie Holmes and Curtis Bilson, Physician Quality Improvement
- Robyn Wells, RN, NRGH Perinatal Harm Reduction Lead
- Juanita Parsonage, NICU Clinical nurse Educator RN
- Shannon Scarisbrick, Pediatrics Clinical nurse Educator RN
- Susan Pantou, NRGH Mother/Child SW
- Julie Rogers, 'Partners in Parenting' Community SW
- Dr. Evelyn Eng, MD OBGYN
- Dr. Sharon Chan-Yan, FMD
- Trina Knight, Child Youth and Family NRGH
- Nicole Puckering, Nanaimo MCFD SW
- Gillian McKay, Patient voice - Grandmother of infant, Primary care provider

aim statement

Increase successful rooming-in of opioid-exposed babies born to medically stabilized mothers at NRGH, to 100% by August 2019, through supporting the mother-baby dyad with a family centered and Trauma informed approach

pdsa cycles

1. Moving all 'at-risk' babies to NICU with mother
2. Antenatal Consultation for at risk families
3. Consistent Care Provider (Pediatrician) to provide consultation service regarding overall care while baby admitted to hospital
4. Education for Staff -Trauma Informed Practice
5. Training of Nurses on pediatrics with scoring tool & education on planned model of care - ongoing
6. Education for Pediatricians regarding planned rooming-in model of care
7. Project Spread - Second stage of project includes planned relocation to Pediatrics Department

background

Opioid-exposed mother-baby dyads are separated at Nanaimo Regional General Hospital (NRGH) when infants show signs of withdrawal and are admitted to Neonatal Intensive Care Unit (NICU). This leads to:

- Newborns separated from mothers
- Impaired early attachment
- Reduced breastfeeding
- Increased withdrawal symptoms
- Increased need for opioid replacement
- Increased length of stay
- Reduced incidence of discharging babies into their mother's care
- Greater MCFD apprehension

patient voice

"Once you become a mother, you become sacred."

- Dirty Lake, Traditional Midwife, Okanagan First Nation

data analysis

- Manual retrospective chart review
- Population included all Opioid exposed Mother/Baby dyads at NRGH from January 2016 - 2019
- Data points: Length of Stay, Breast feeding incidence, discharge of intact mother-baby dyad

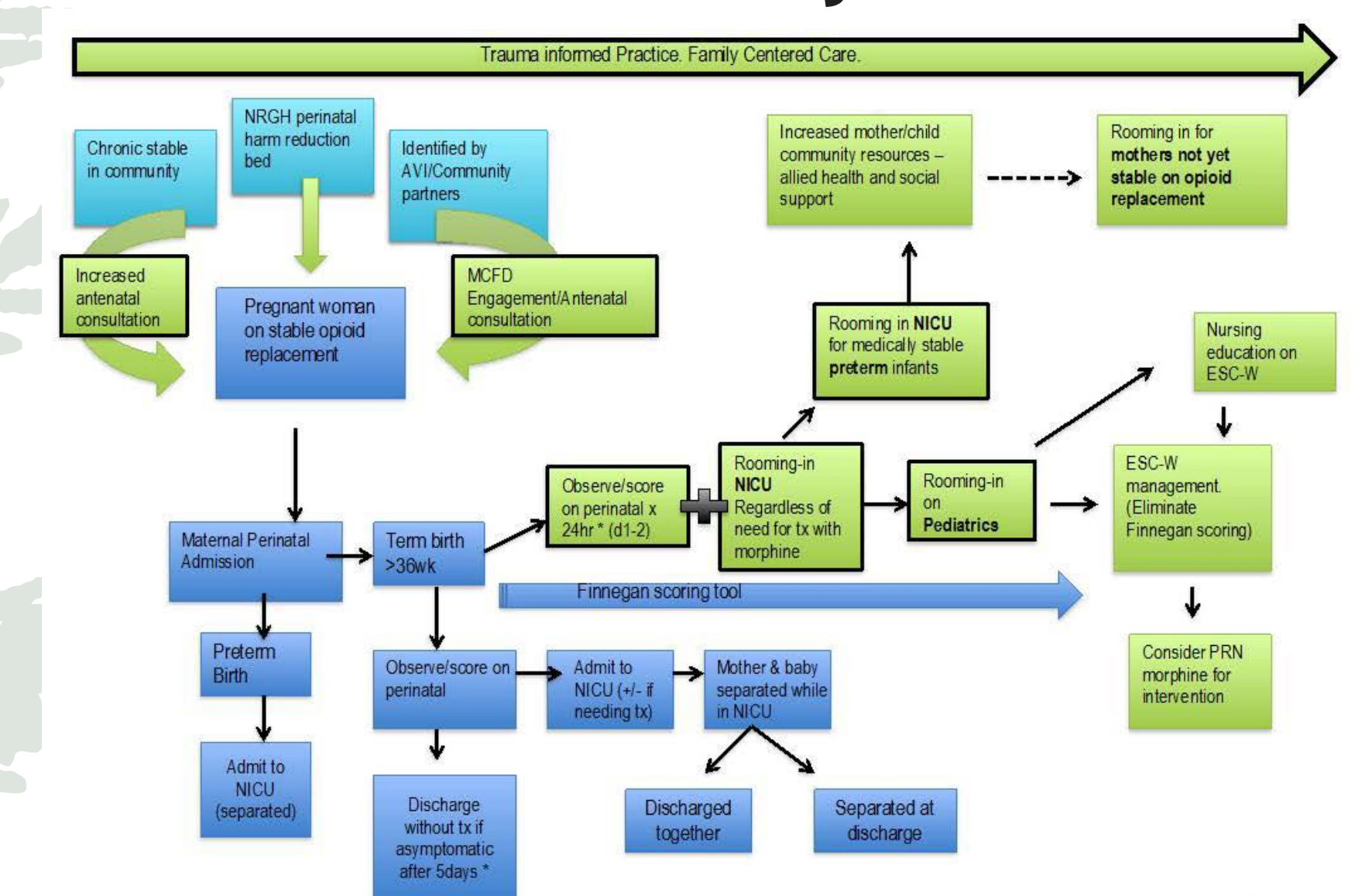
problem

Separation of an infant from their opioid - dependent mother increases the risk of the infants experience of withdrawal and distress, resulting in dramatic influence on early attachment opportunities.

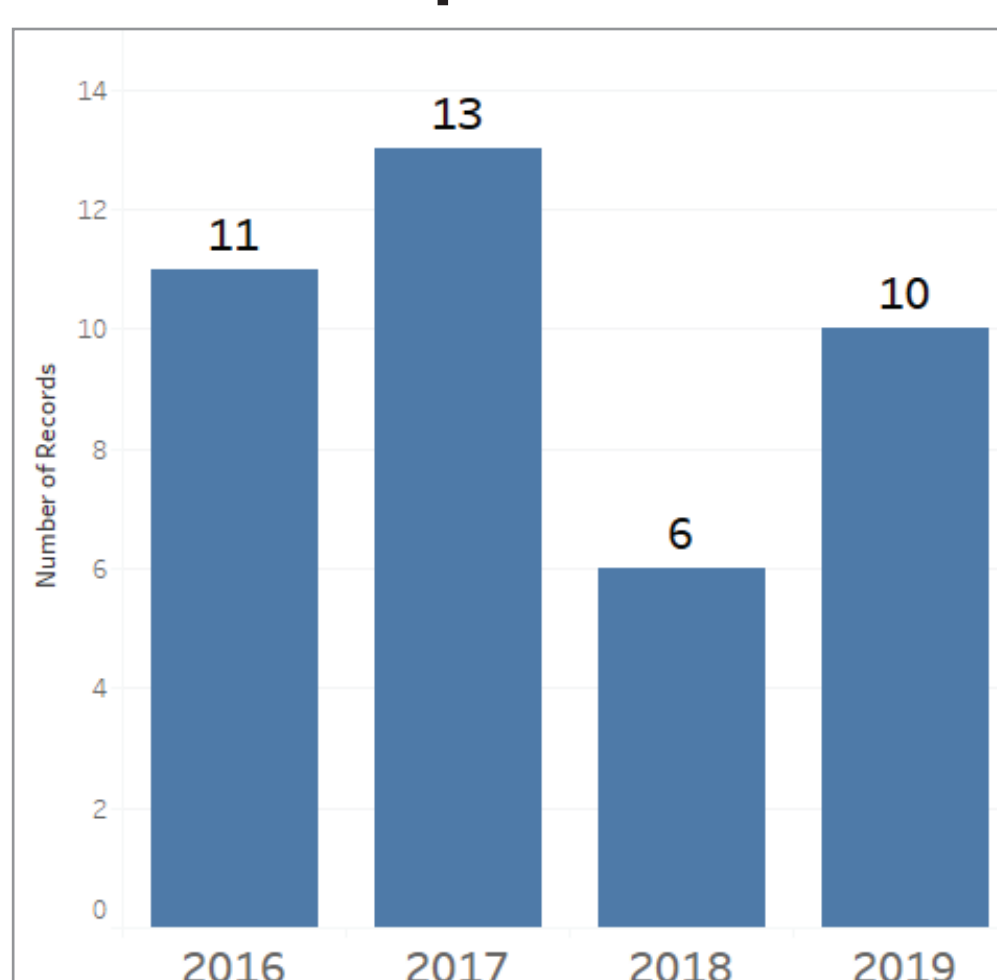
change idea

- Communication tools with staff (nursing and social work) and with providers (Nurses, OB, Midwives)
- Request for Antenatal Consultation with Pediatrician for planned births for those with opioid exposure in utero
- Staff Education on Trauma Informed Care for this often stigmatized and highly at-risk population
- Questionnaires for staff feedback regarding areas of education need
- Relocation of infants to NICU with mother/family during entire length of stay after immediate post-partum stabilization
- Education for nursing on Pediatrics for planned relocation of mother-baby dyads from NICU

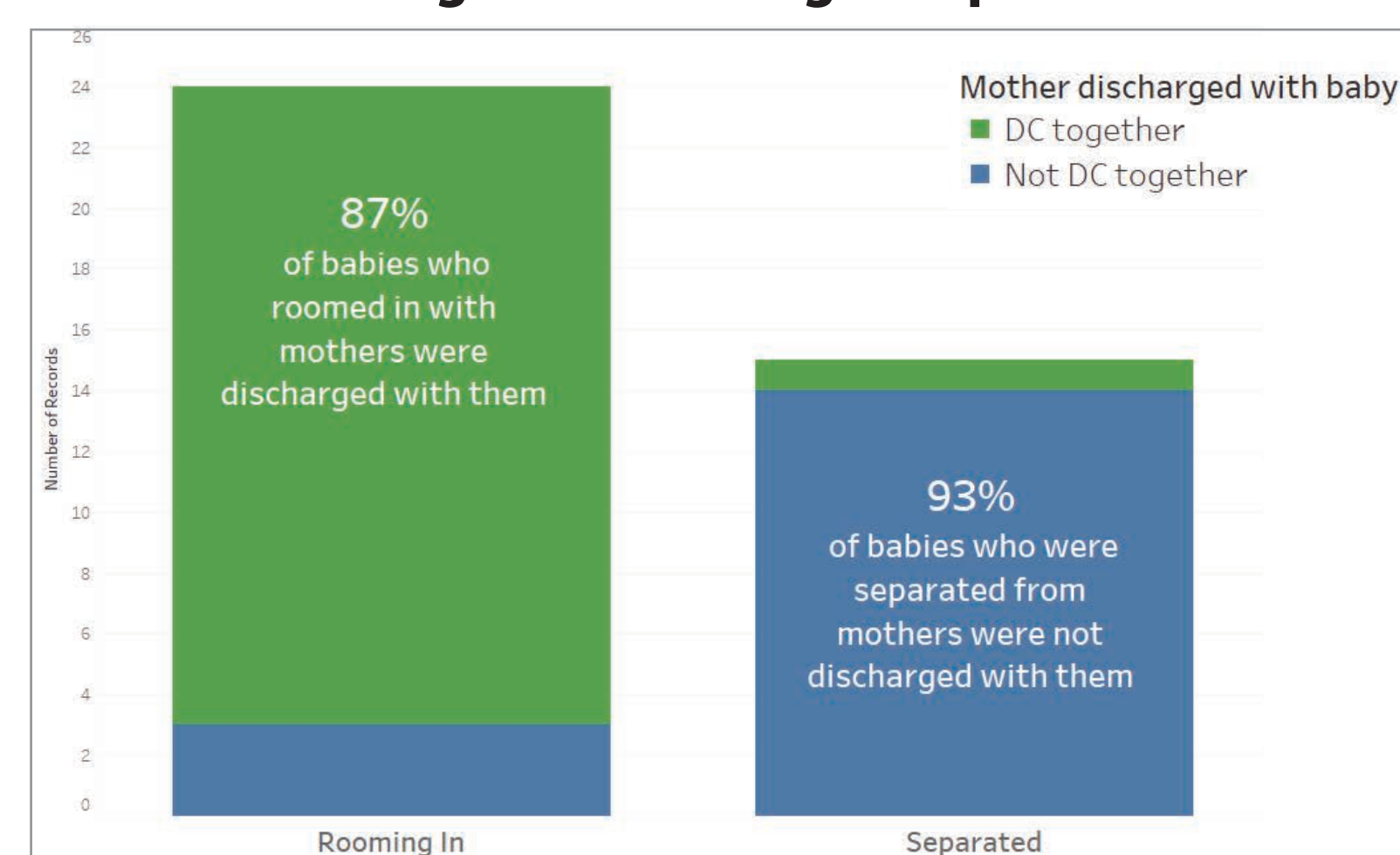
Cedar Circle Project Flow



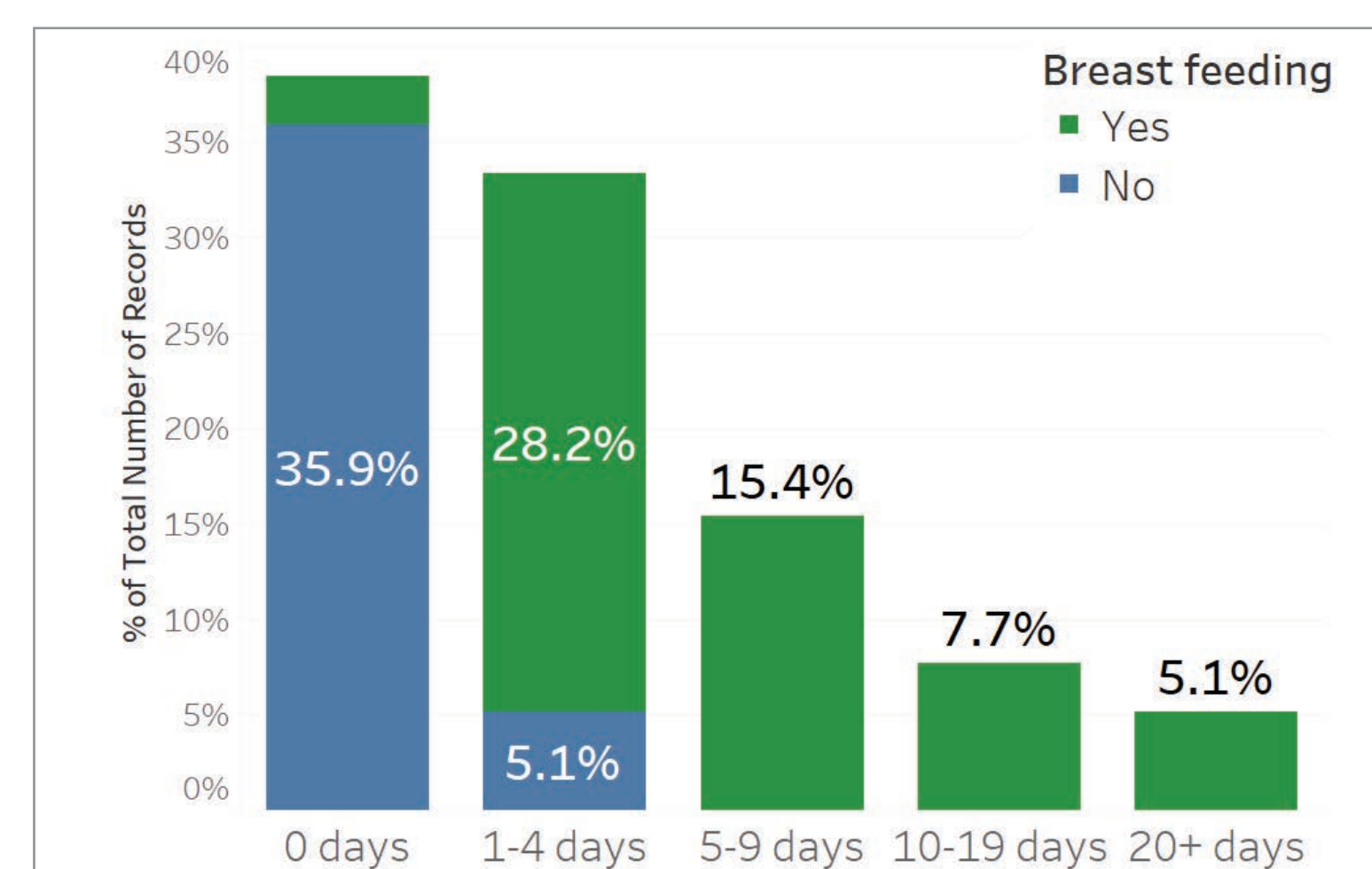
Encounters per Year at NRGH



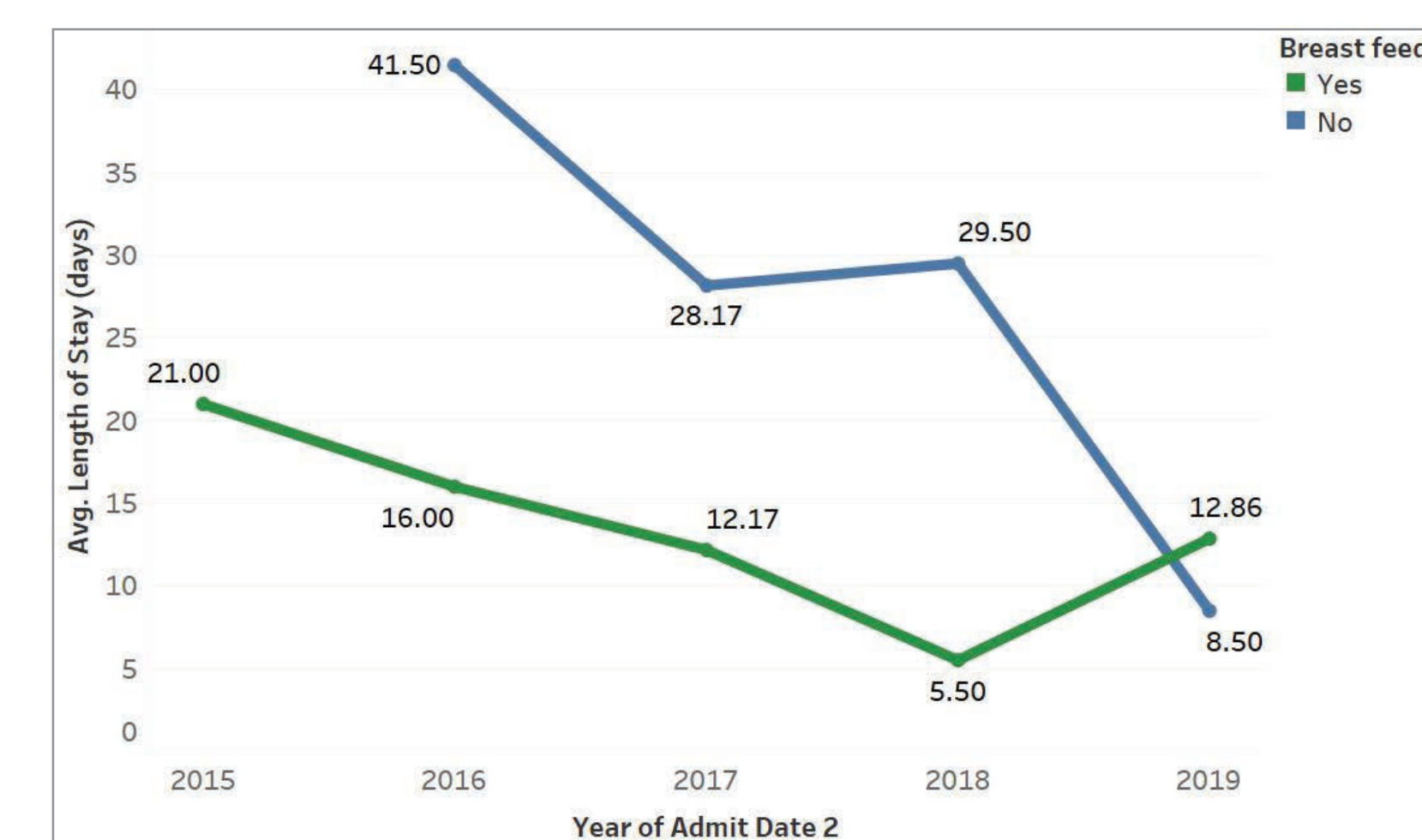
Rooming In // Discharge Disposition



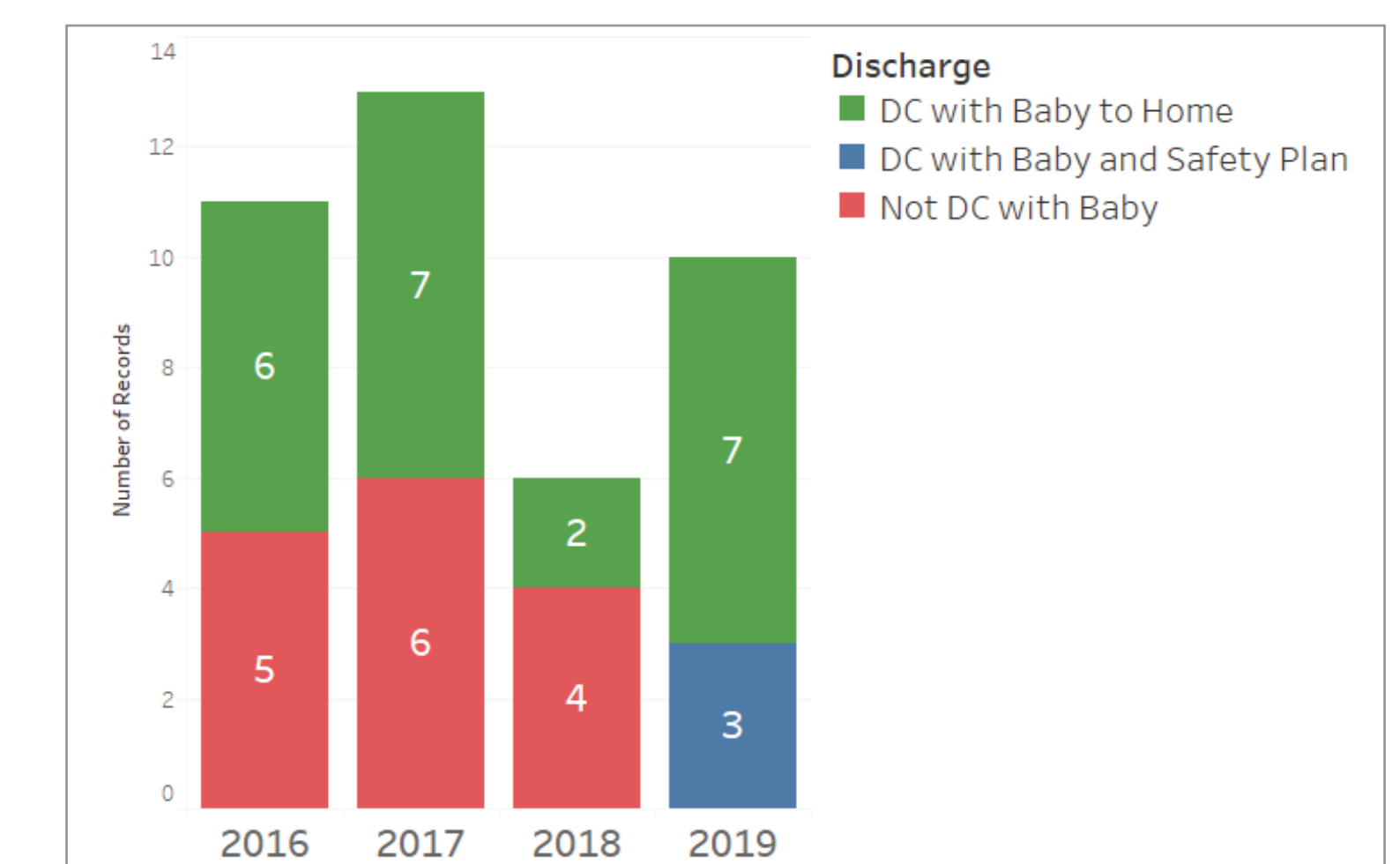
Days Rooming In // Breastfeeding



Average Length of Stay (days) // Breastfeeding (per Year)



Discharge Outcome by Year



findings

Rooming mother and baby dyads is associated with improved incidence of ongoing breastfeeding, improved success of discharge of intact mother-baby dyad, reduced need for pharmacologic intervention for infant withdrawal symptoms.

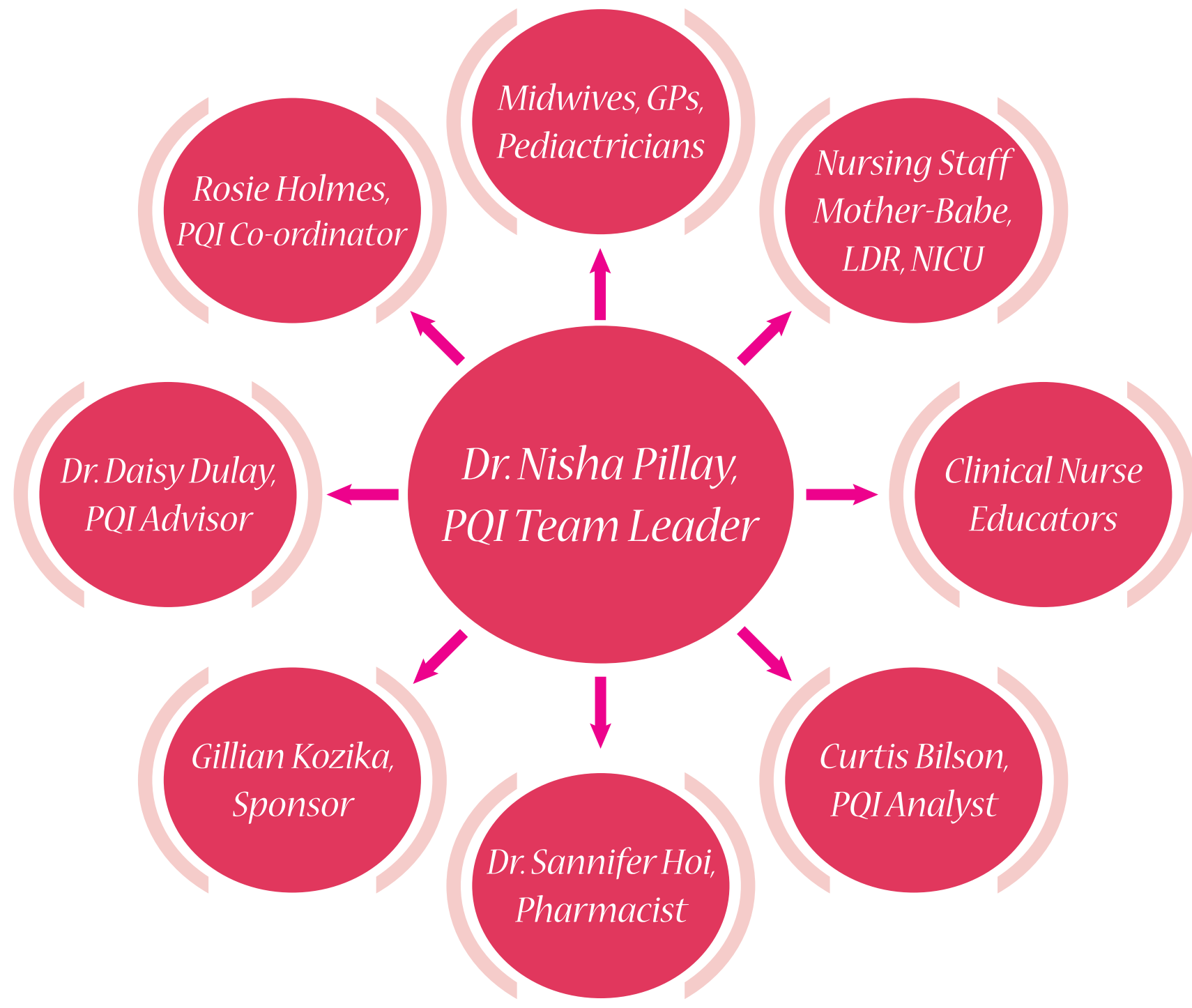
conclusion

Rooming in is now seen as national standard of care and is endorsed by the Canadian Pediatric Society (CPS) in institution recommendations and guidelines. Improved outcomes for mother and infant are seen, including improved success of ongoing breastfeeding at discharge, improved attachment and bonding, reduced symptoms of withdrawal and therefore reduced requirement for pharmaceutical intervention with opioid replacement. Patients prefer a rooming-in approach as it involves the family in family-centered care. Staff education in Trauma Informed Care aids delivery of care in a culturally safe and sensitive environment, acknowledging the past impact of trauma, and seeking to minimize propagation of further potential trauma during a critical stage of bonding and attachment.





Project Team



Background

Prior to 2019, the at risk hypoglycemic newborns at the Victoria General Hospital (VGH) were generally admitted to the Neonatal Intensive Care Unit (NICU) and received a glucose level at 2 hours of age or following a low glucose level in the Mother-Babe unit, the newborns were subsequently admitted to the NICU for further monitoring.

This mother- infant separation resulted in:

- disrupted maternal / infant bonding
- increased maternal anxiety
- breastfeeding failure.

For these reasons, other effective and less invasive options that may prevent the need to treat with IV dextrose and avoid separation are highly desirable.

Problem

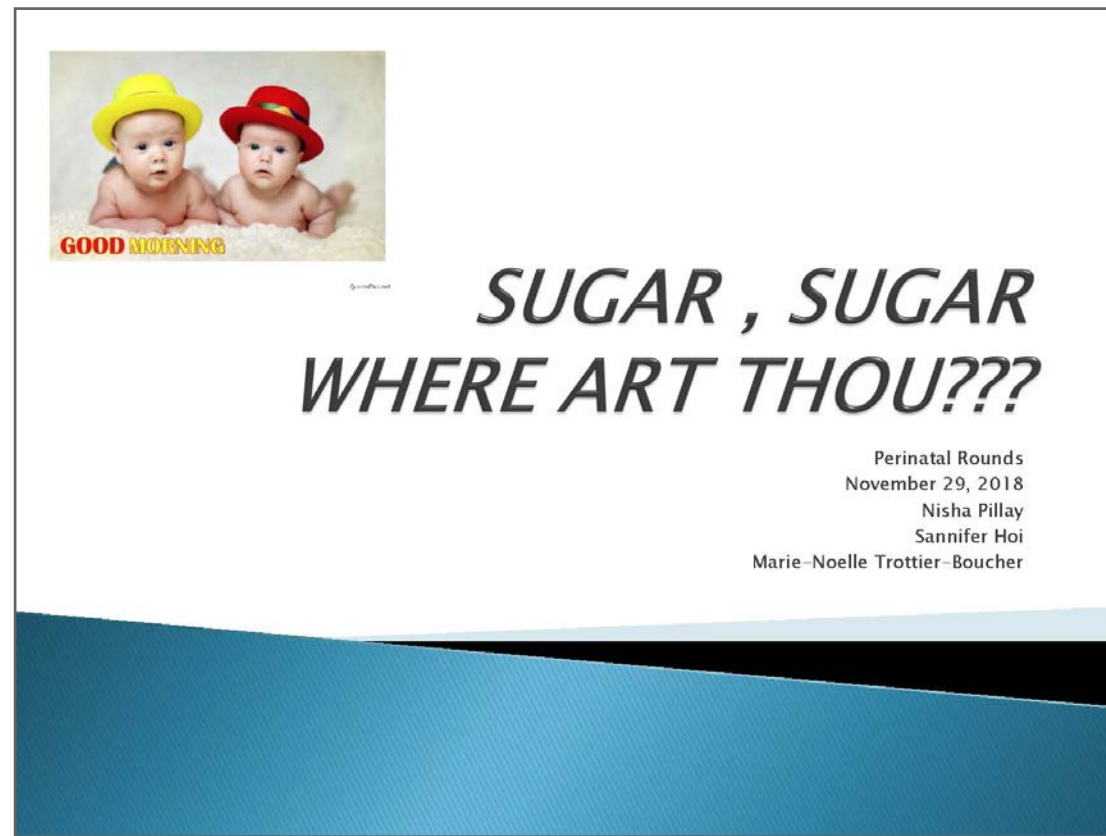
Criteria for at risk newborns:

- Infant of a Diabetic Mother
- Less than 37 weeks GA
- BWT < 10% ile
- BWT > 90% ile.

During this period of the newborn in the NICU, they are separated from their mothers, breastfeeding is delayed and parents commonly feel their babies are abnormal due to this separation.

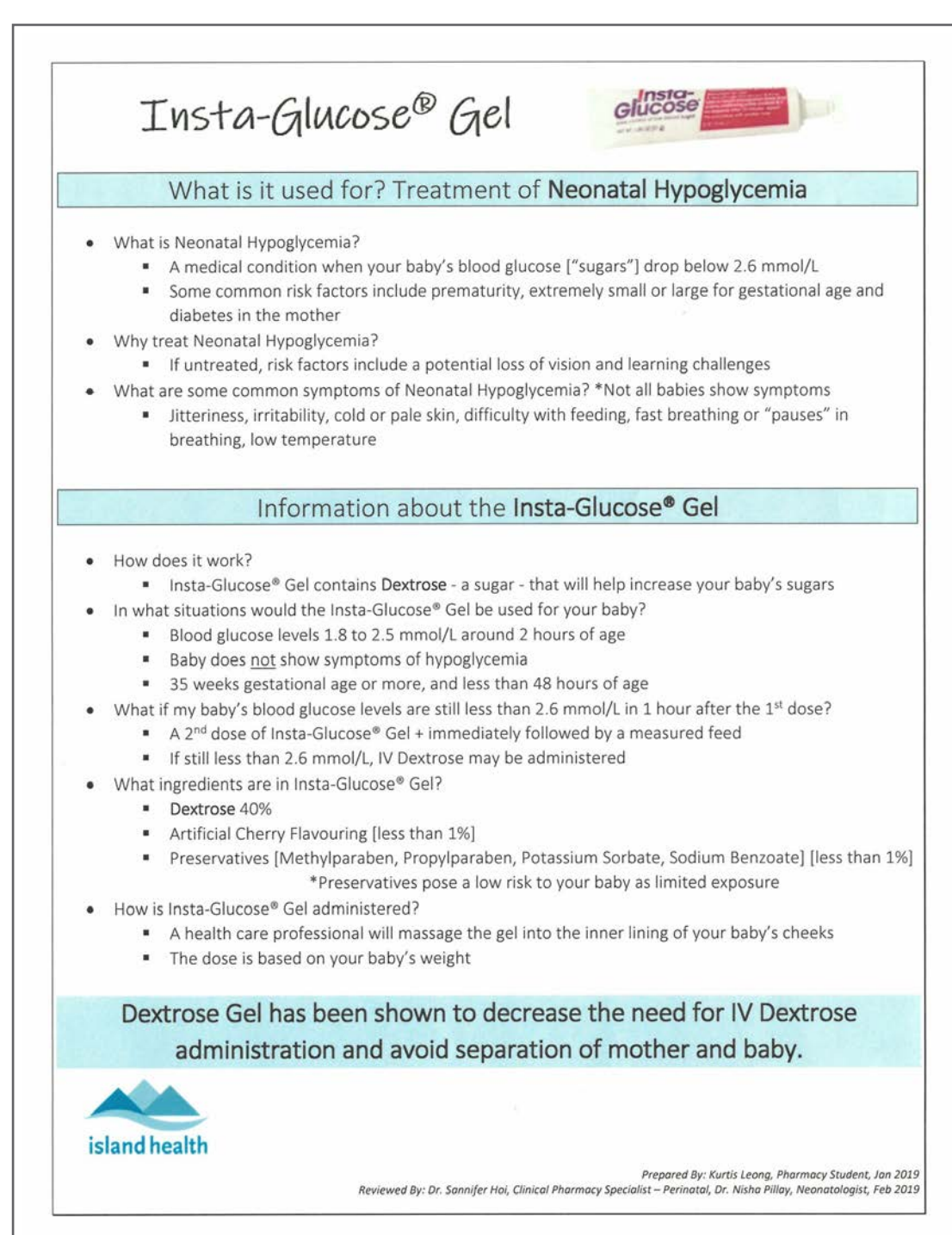
PDSA Cycles

PDSA 1: Dextrose Gel 40% implemented following nursing education



PDSA 2: Development of a data collection sheet for staff to use

PDSA 3: Concerns on viscosity of gel and red dye. This Resulted in Parental Handout with information.



Change Idea



Starting in January 2019, we have implemented the use of Dextrose Gel 40% at VGH to our current hypoglycemia protocol for the at risk hypoglycemic newborns.

An audit tool is completed by nurses.

AIM Statement

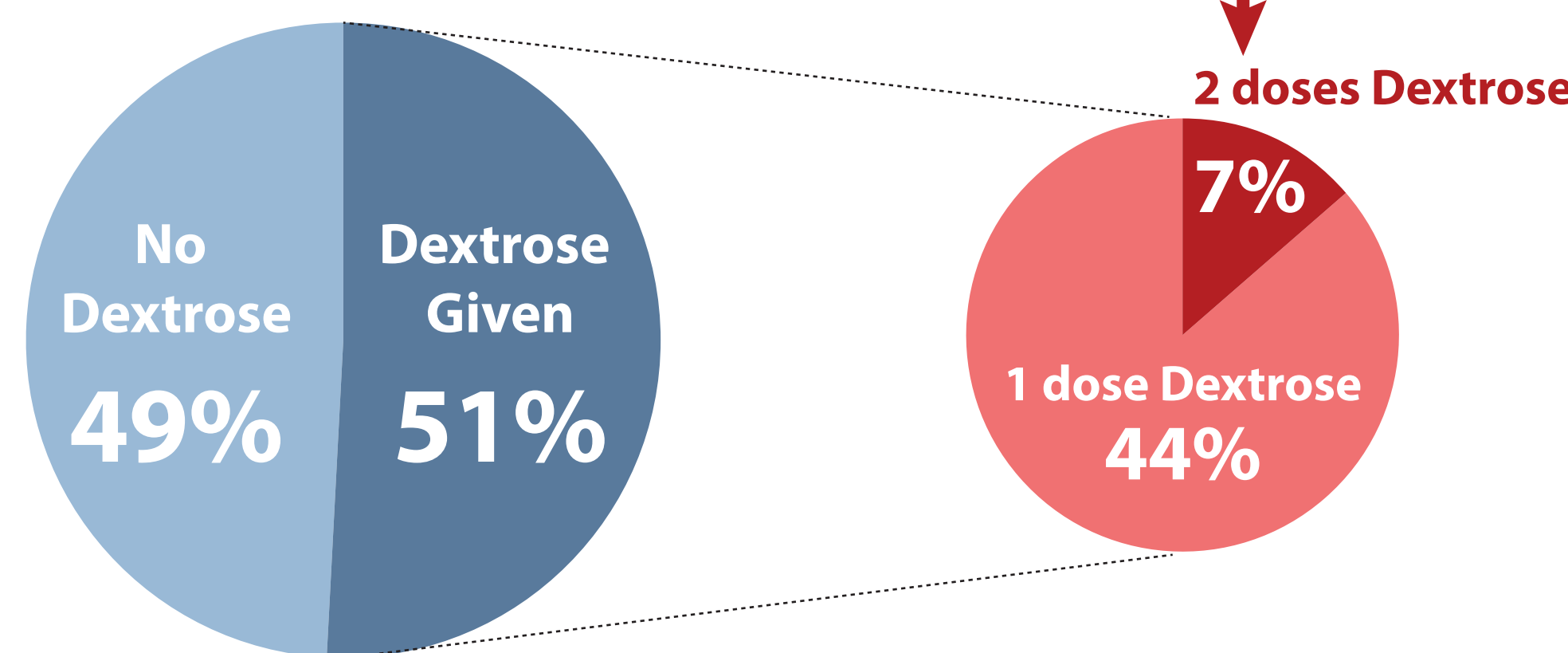


We aim to improve the Mother-Babe Dyad without compromising the care of the at risk newborns through implementation of the use of Dextrose Gel 40% at VGH by 85% by the end of September 2019.

Data Analysis

1. You usually only need one dose

Of the 138 candidates recorded in this project we found that 51% met criteria for Dextrose Gel procedure. 44% required 1 dose of Dextrose Gel, while less than 8% required a second dose



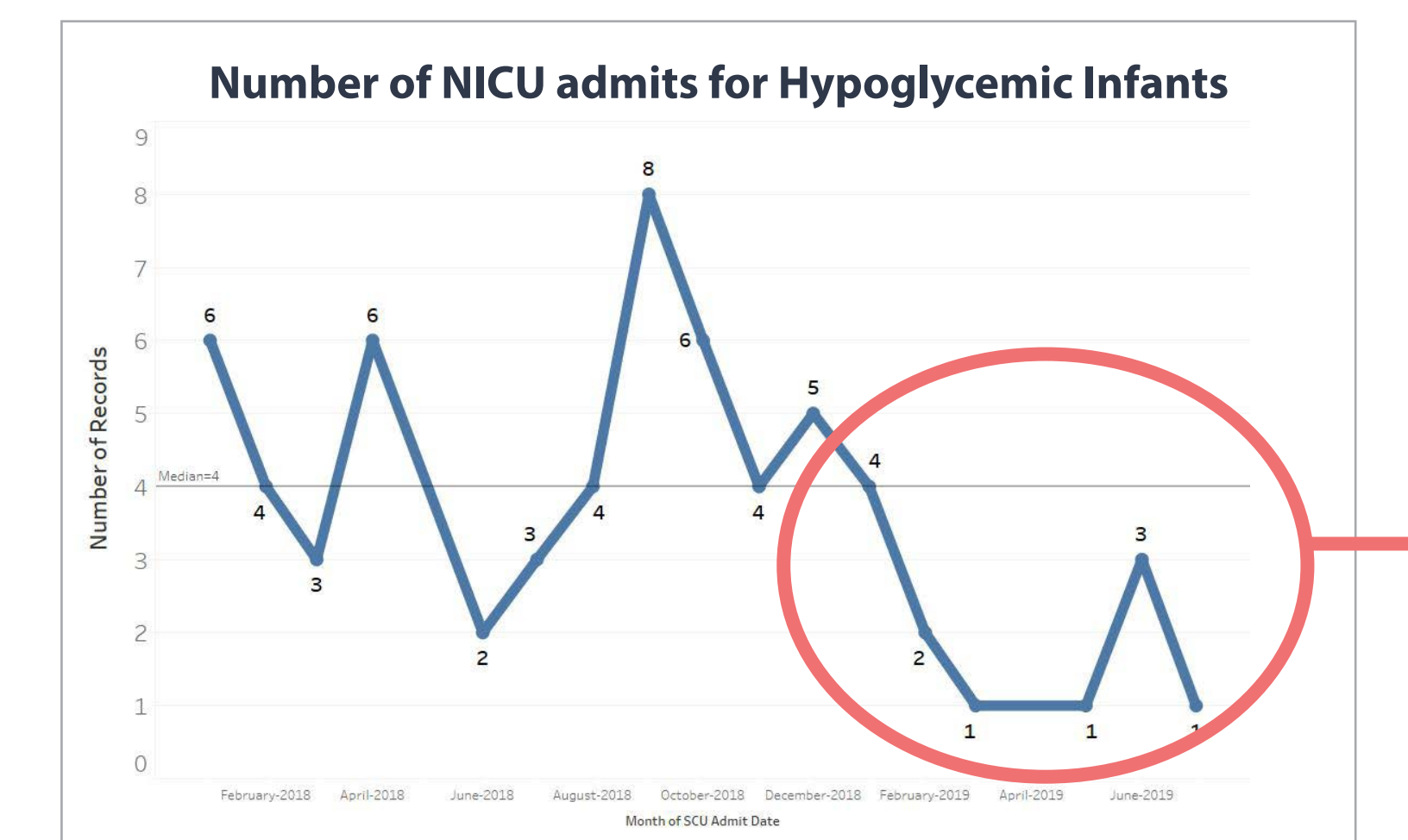
2. Less admits to the NICU

Comparing the numbers from the same time frame from the past 2 years we see that admissions to NICU for babies with hypoglycemia has dropped

Year	2017	2018	2019
Time Frame	Jan - June	Jan - June	Jan - June
# of NICU admits for hypoglycemia	36	24	only 13! (46% decrease from prev year)

3. System improvement indicated

The identification of 6 data points on or below the median line signals there has been non-random change in how the system is working



Project Spread

1. "Sugar Sugar where art thou?" - Perinatal Rounds capturing:
 - midwives
 - family physicians
 - pediatricians
2. Regular education days with nursing staff.
3. Journal kept in resource room for anonymous nursing feedback.
4. Parental Handout with information on the administration of Dextrose Gel 40%.

Future Direction

The hope is to have the Dextrose Gel 40% available and incorporated island wide as part of the hypoglycemia protocol. As the gel does contain less than 1% preservatives, which does pose a low risk, it would be ideal to have a custom made neonatal dextrose gel.



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



BACKGROUND

- Pregnancies can be difficult for any women, but can be especially difficult for those who are affected by substance use
- There are numerous gaps in care for this vulnerable population
- It is very difficult to identify and characterize the features of women who use substances during their pregnancy.
- Women often encounter numerous barriers to access services for addictions and maternity care at the same time
- Typically services for addiction care are not located in the same location of maternity services, leading patients to travel to numerous healthcare sites
- There are no policies or standardized care plans to ensure these mothers get access to timely acute care services
- Improvements need to be made to allow for rooming-in for this mother-babe dyad

PROBLEM

At present, there is currently no mechanism in place to identify features of women who use substances during pregnancy nor is there a system in place to ensure they can access low barrier, co located services for addictions and maternity care.

AIM STATEMENT

We will improve identification by 100% for pregnant women who use substances and who wish to access maternity and addiction care at VGH, RJH and in the community by August 2019

CHANGE IDEA

What changes can make that will result in improvements?

- To offer this patient population non-judgmental, woman-centered, evidence based trauma informed care with a harm reduction lens
- To deliver education about this patient population to diverse care providers
- To develop a centralized referral process to Perinatal Addiction Services
- To develop a Clinical Order Set for Antepartum/ Intrapartum and Postpartum patients affected by substance use

PDSA Cycle 1 Baseline Survey Data

Question: "On a scale from 1 to 10, how comfortable are you with managing your patients with addictions concerns?"

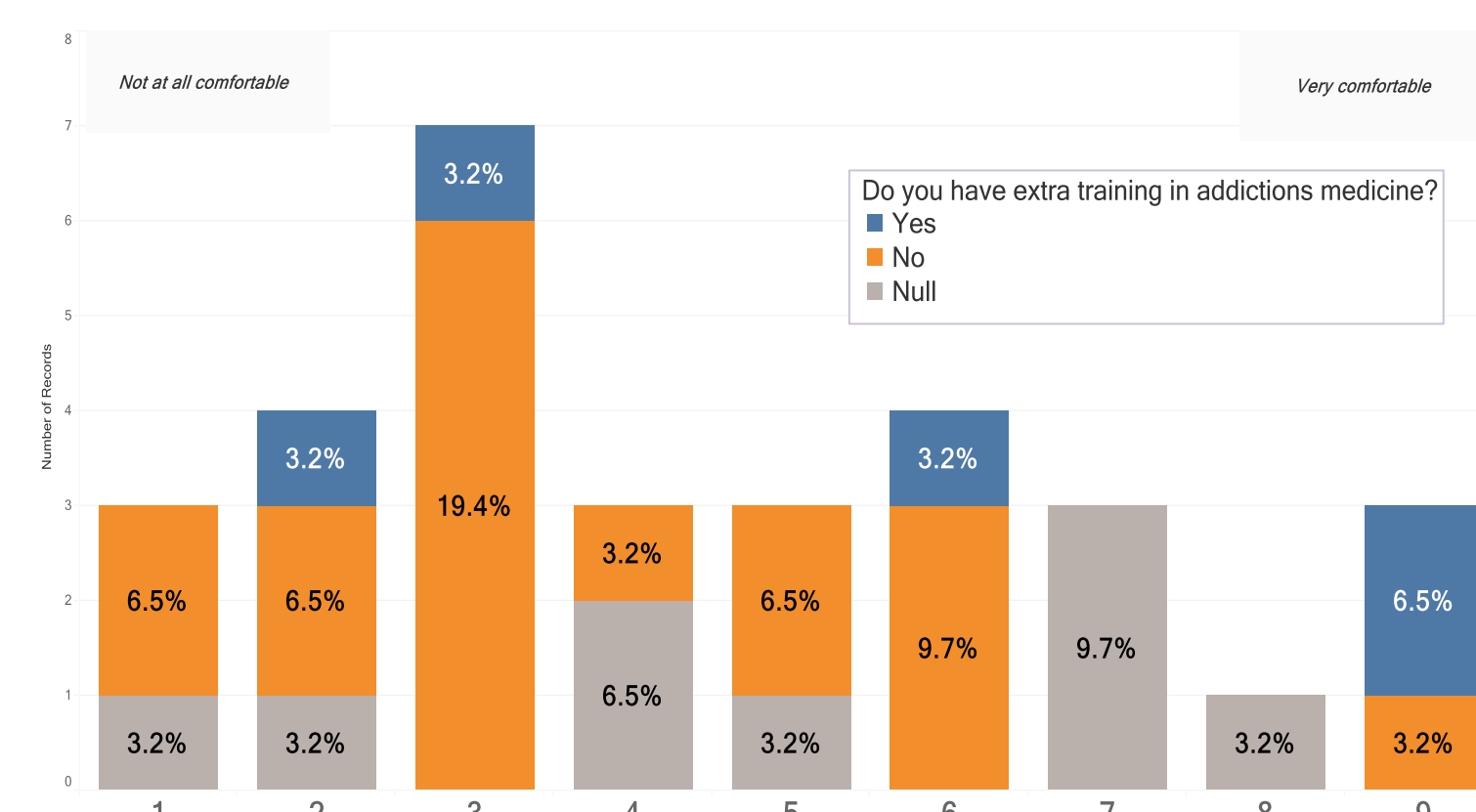
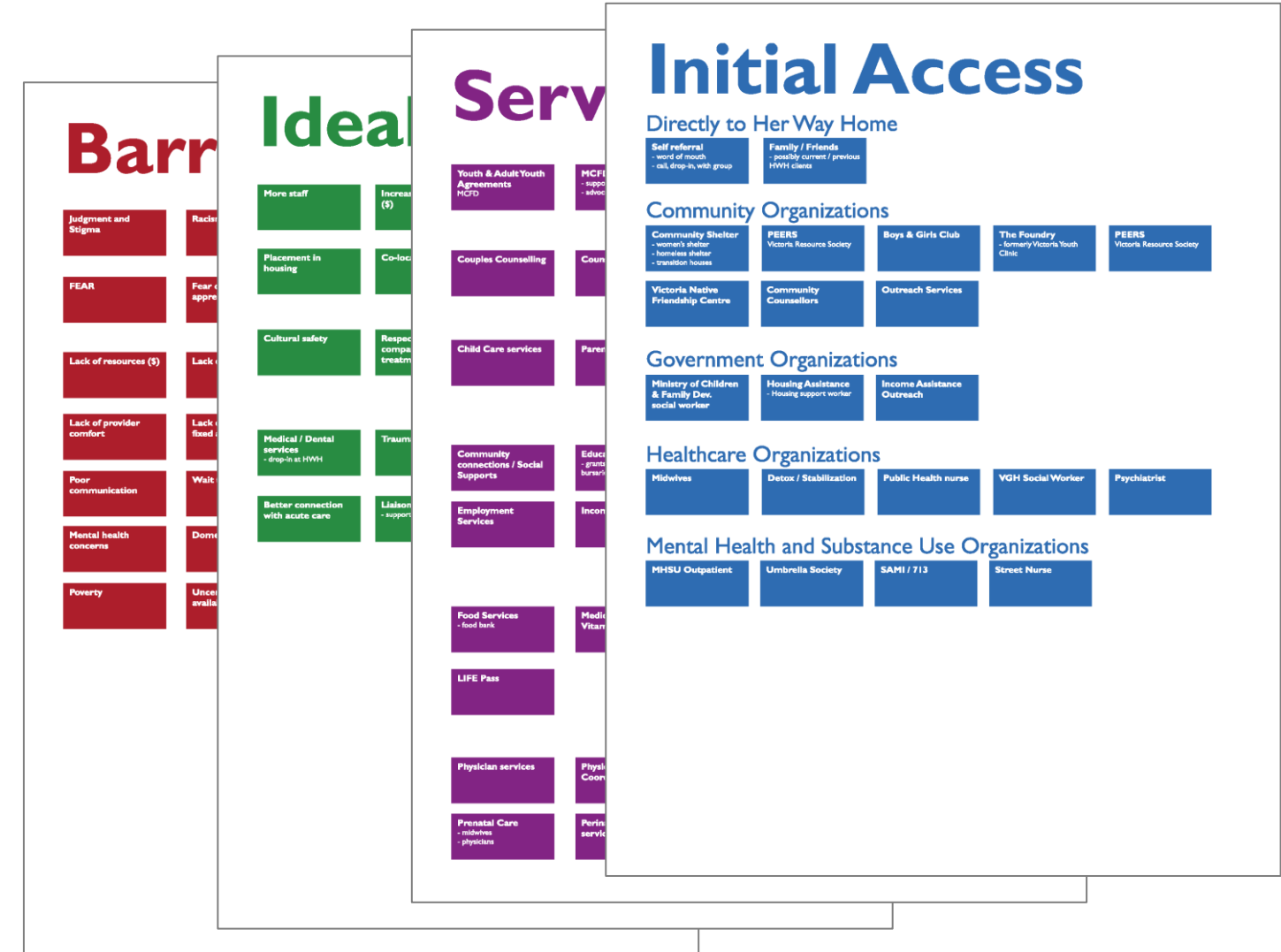


Table 1. In November 2018 a survey was given to healthcare staff. Results showed that:
1. Only a small minority of respondents indicated they have extra addictions medicine training (16.1%)
2. Majority of respondents (54.9%) did not feel comfortable managing patient addictions concerns (scored 4 or lower)
3. Even respondents with extra addictions training (in blue) still did not feel comfortable managing patient addictions concerns (scored only 2 or 3 out of 10)

PDSA Cycle 2 Process Inventory

In March of 2019 Dr. Lea and the PQI Team met with the HerWay Home Staff to develop a 'process inventory' to highlight different aspects of the patient's interaction with the healthcare system including **initial access, services required, ideal resources, and barriers**



PDSA Cycle 3 Staff Resource List

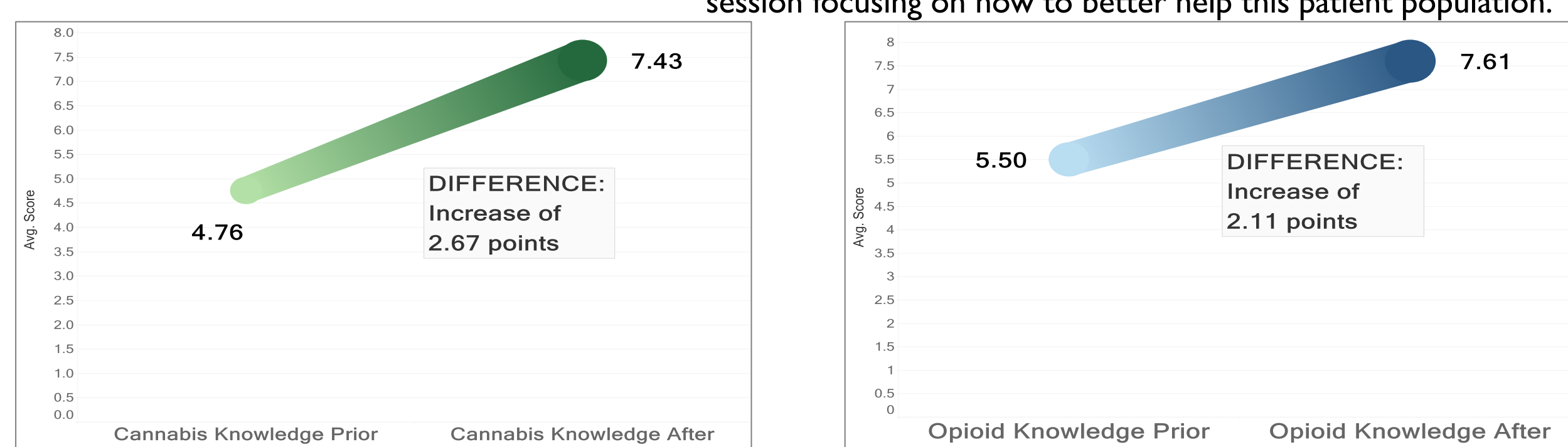
During the project a **Staff Resources List** was developed that outlined resources and related organizations to contact regarding drug use & pregnancy, addictions resources, alcoholics anonymous groups, safe injections sites as well as other important resources. We are currently developing a similar **Information Pamphlet** for patients.

PDSA Cycle 4 Developing COS

With the assistance of a Medication Safety Consultant the team is currently developing a standardized Clinical Order Set (COS) that will outline many requirements for this patient population, and is expected to be deployed across the health authority.

PDSA Cycle 5 Education Event

In May of 2019 Dr. Lea led an education dinner event to physicians, nurses, and allied medical staff. During the event Dr. Lea conducted a presentation on cannabis and opioid use, HerWay Home presented on their community services, and there was an interactive audience session focusing on how to better help this patient population.



Average score of attendees pre/post event surveys: Those attending the dinner event were asked (on a scale of 1 to 10) their level of knowledge and their level of comfort before and after the presentations, for both cannabis and opioid information for patients:
- on average attendees knowledge of cannabis information increased 2.67 points from the event
- on average attendees knowledge of opioid information increased 2.11 points from the event

PATIENT VOICE

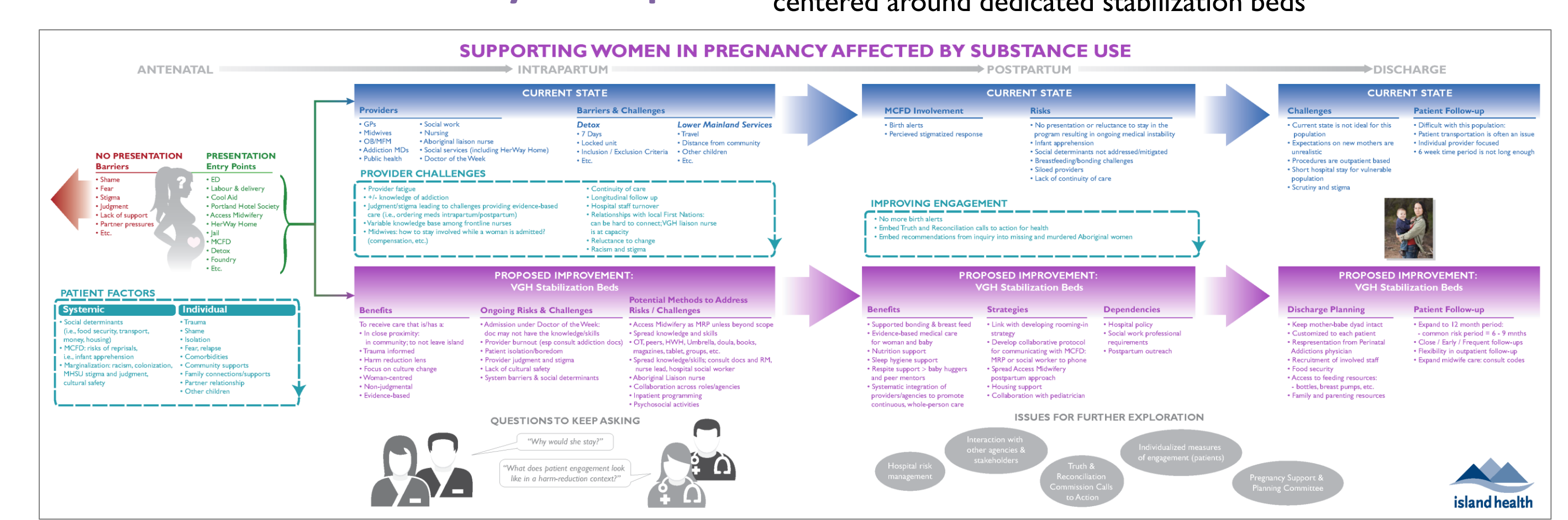


"I was very happy with the care I received from Dr. Lea and her team. Dr. Lea is caring, I saw her as both a friend and as a doctor"
- Mom to Baby S

Dr. Lea worked with Baby S's Mom throughout her pregnancy to help her achieve and maintain abstinence and they are happily thriving together in the community with the help of HerWay Home and the Perinatal Addiction Physician Team.

PDSA Cycle 6 Patient Journey Map

In collaboration with the Shared Care Committee this project developed a **Patient Journey Map** that compared the current state of this patient's interaction with the healthcare system with the a purposed system improvement centered around dedicated stabilization beds



CONCLUSION

Over the course of the year, through advocacy and education, we saw a shift in culture in the acute care setting. This has led to a qualitative improvement in women's experience in the inpatient department. Staff have expressed a desire and interest to learn more about caring for this population, and data from our educational event showed a significant gain in knowledge from our pre-and post event surveys. Through this culture shift and improved patient experience we are seeing more women present to care, and be willing to access services they may have otherwise avoided due to fear of judgment, child protection concerns etc. We are admitting more women for stabilization, and in turn they are reporting positive experiences of their stay in hospital.

FUTURE DIRECTIONS

- Educational Rounds for local practitioners
- Development of Perinatal Addictions Referral Form
- Build strong interdisciplinary relationship with perinatal psychiatry to improve psychiatric care in pediatrics and offer prolonged post-partum stays for infants requiring treatment for neonatal opioid withdrawal syndrome (NOWS)
- Continue to build community supports and resources with groups such as Emergency Medicine providers, Divisions of Midwifery, and Divisions of Family Practice
- Advocate for supportive housing and a shift in culture with MCFD to support mother and baby dyad in early parenting

PROJECT TEAM

PQI Physician Lead:
Dr. Kathleen McFadden

Project Participants:

- Helen Goodwin
- CRH 3rd Floor Unit C/D staff
- Laura Hickey, Patient Partner

AIM STATEMENT

To increase the number of patients who are 70 years and older with one complex medical problem at Campbell River Hospital (CRH) sitting up in a chair for meals by 50% by August, 2019.

PDSA Cycle



Score cards & magnets

- Distributed to patients meeting project criteria.
- Completed scorecards provided to Unit Clerks.
- Measure uptake via number of scorecards submitted.

DATA ANALYSIS

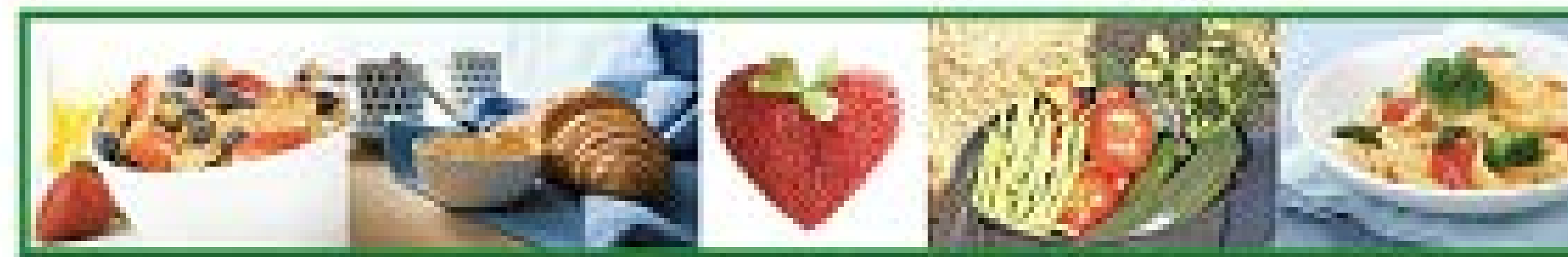
Baseline data included a manual count of patients who met project criteria at CRH to determine:

- Location where meal eaten (bed, chair, at table etc.)
- Age (70 – 96 years)
- Unit
- Day of the week
- Reason for not sitting up (too tired, fasting etc.)

FINDINGS

- 81.8% of patients 70+ eating meals in bed with a tray.
- 32.35% of patients required assistance getting up and/or eating.
- Patients between 80-89yrs least likely to be up for meals (36.36%)

I GET UP FOR MY MEALS



Let's Get up to Eat!

"Healing is a matter of time, but it is sometimes also a matter of opportunity."
- Hippocrates (460 BC - 370 BC)

Island Health is committed to helping you reach your health goals! Did you know that every day of bed rest makes it harder to recover from illness or surgery? In fact, you lose 1 – 2% of your muscle strength every day you spend in bed!

Getting up in the chair in your room to take your meals is a great place to start for almost everyone with the goal to achieve the best health possible.

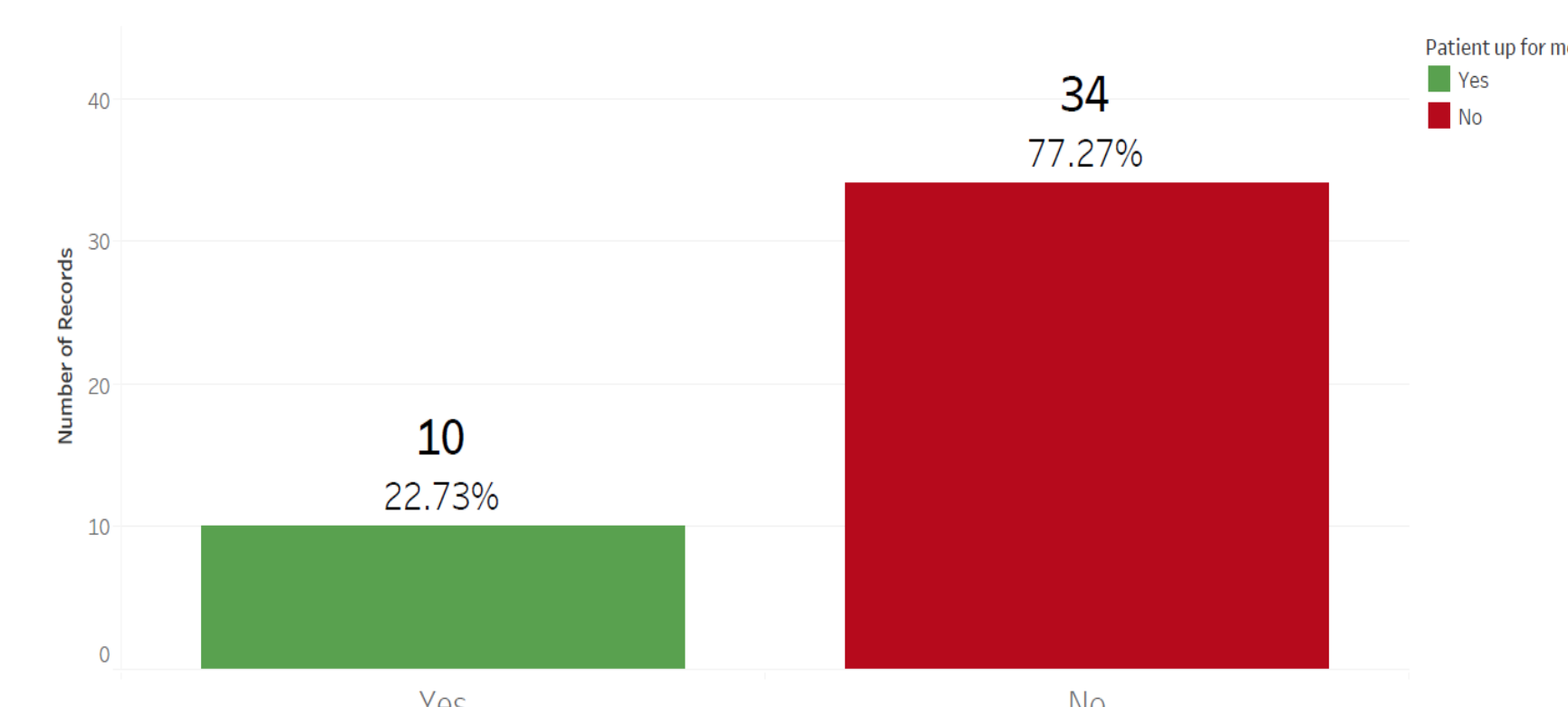
Use the back of this sheet to record every time you are your meal in a chair!



BACKGROUND

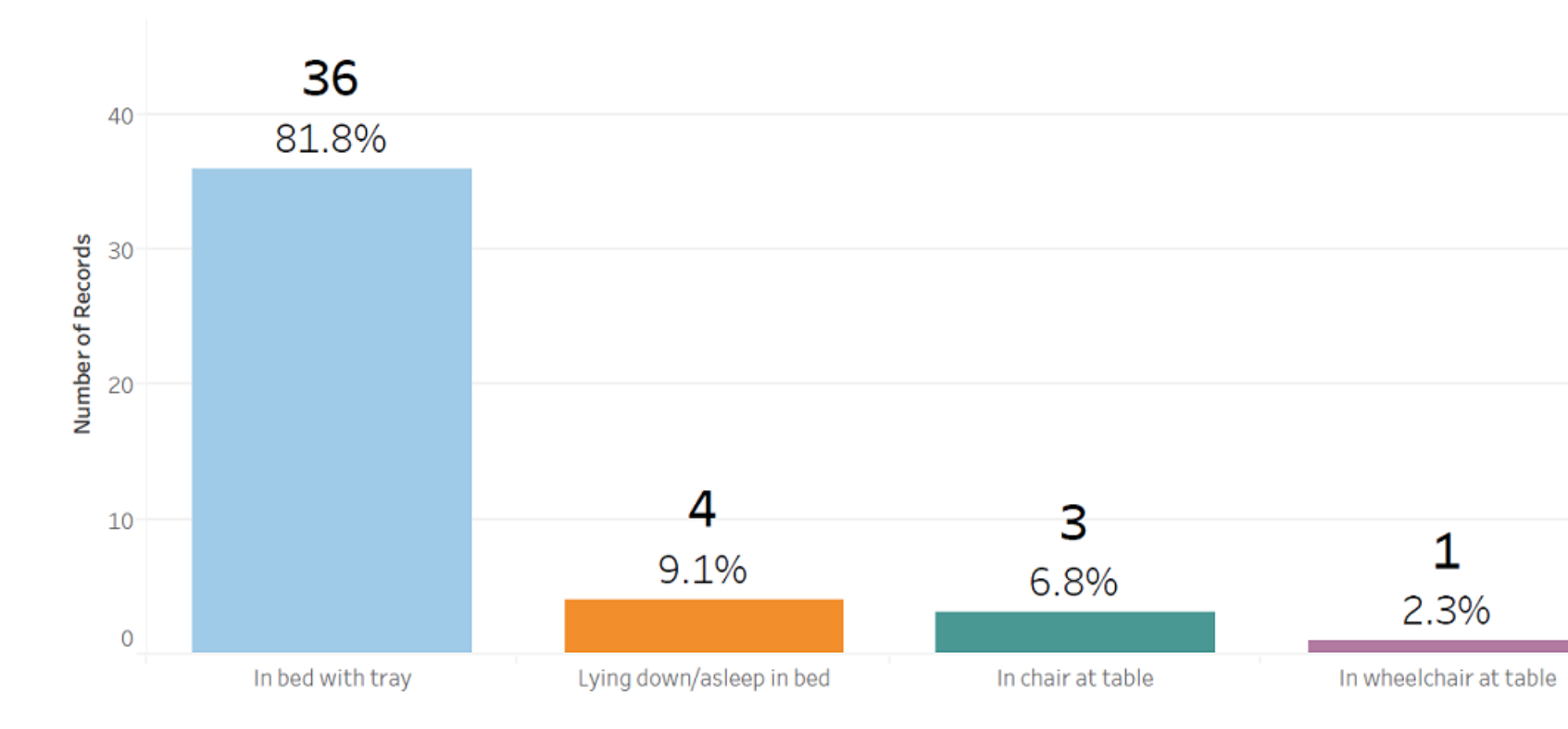
Evidence demonstrates that encouraging patients to sit up for their meals is associated with better health outcomes and decreased lengths of stay.

Physician Quality Improvement (PQI)
Optimizing Care for Elder Patients at CRH
February - March 2019
Patient sitting up for meals!
Number of Records
Percent of Total



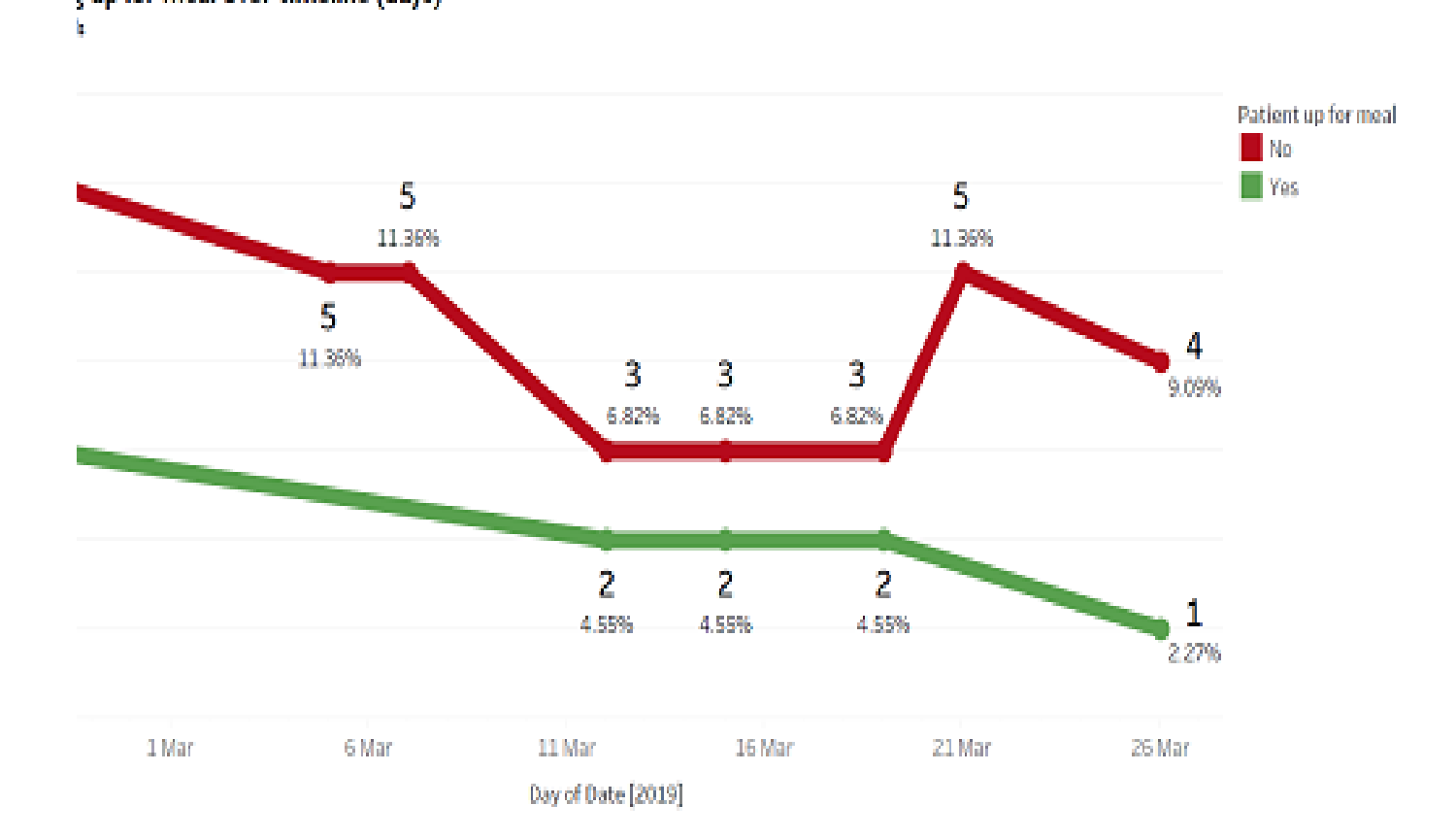
February - March 2019
Encounter Site: Campbell River Hospital
Patient: 70 years in age, admitted into hospital
Physician Lead: Dr. Kathleen McFadden
Data Analyst: Curtis Blison
Data Source: Primary Data Collection
PQI is a collaboration between Island Health and the Specialist Services Committee

Physician Quality Improvement (PQI)
Optimizing Care for Elder Patients at CRH
February - March 2019
Location of patient during meal
Number of Records
Percent of Total



February - March 2019
Encounter Site: Campbell River Hospital
Patient: 70 years in age, admitted into hospital
Physician Lead: Dr. Kathleen McFadden
Data Analyst: Curtis Blison
Data Source: Primary Data Collection
PQI is a collaboration between Island Health and the Specialist Services Committee

Physician Quality Improvement (PQI)
Optimizing Care for Elder Patients at CRH
February - March 2019
Up for meal over timeline (days)
Number of Records
Percent of Total



CRH
Campbell River Hospital
Patient: 70 years in age, admitted into hospital
Physician Lead: Dr. Kathleen McFadden
Data Analyst: Curtis Blison
Data Source: Primary Data Collection
PQI is a collaboration between Island Health and the Specialist Services Committee

CONCLUSION

Discuss final thoughts surrounding the project

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PROBLEM

Frail elderly patients at CRH seem to be deteriorating clinically with prolonged hospital stays.

CHANGE IDEA

Encourage patients to sit up in a chair for their meals by introducing a patient-driven “score card” tool and a white board magnet to remind staff and visiting family/friends.

PROJECT SPREAD

- Endorsement of operational leaders crucial.
- Changing hearts and minds: enlisting front-line champions.
- Consider “Upstream” process changes
- Look to established initiatives for help (e.g. ‘PJ Paralysis’ program.)

PROJECT TEAM

Chaundra Willms *NP Co-Division Head* – Project Lead

- Chris Hall *EMD Medical and Academic Affairs* - Sponsor
- Coleen Heenan – *NP Co-Division Head*
- Koko Tokoro – *NP Cardiac Services R/H*
- Carolyn Carlson, Chelsea Wakelyn, & Curtis Bilson – Physician Quality Improvement

BACKGROUND

Concerns about Nurse Practitioners prescribing blood in acute care.

- Local experts indicate that there is inappropriate prescribing of blood products in acute care
- Concerns were expressed that NPs might not have adequate educational preparation to prescribe blood and blood product and should not prescribe blood independently
- NP scope includes prescribing blood after additional education

CHART AUDIT

- Chart review:** 30 inpatients at R/H prescribed blood in September 2018
- Excluded:** oncology, trauma, & ICU
- 23 patient charts remained
- All charts were physician orders

Choosing Measures:

Most common measures used to evaluate appropriate Packed Red Blood Cell (RBC) transfusions

- % of transfusions with a pre-transfusion hemoglobin ≤ 80 g/l
- % of single unit red blood cell transfusions.

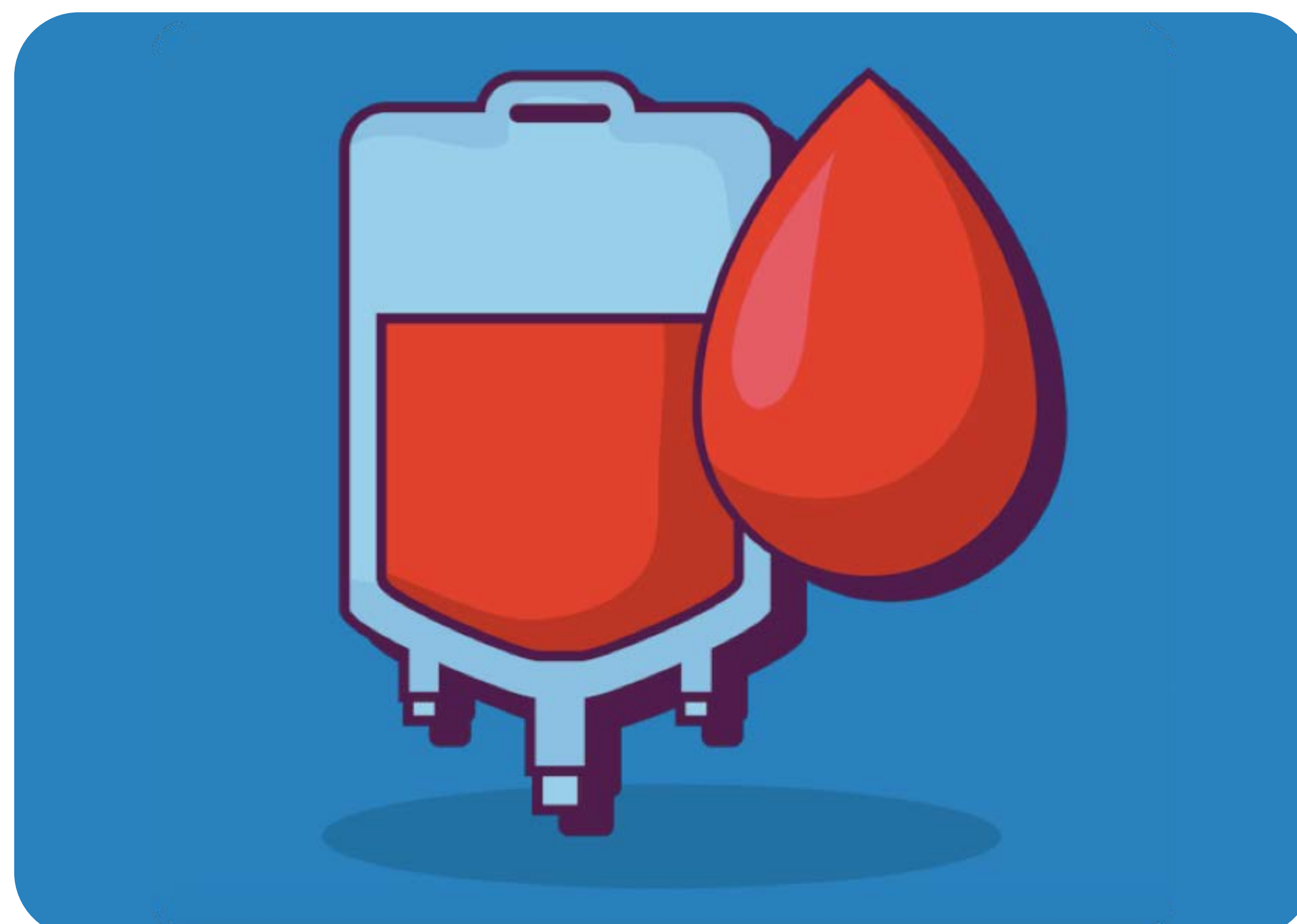
FINDINGS

- 73.9%** of transfusions patient HGB < 80
- 39.1%** of transfusions 1 unit

26.1% of prescriptions met *Choosing Wisely Canada* Transfusion Recommendations



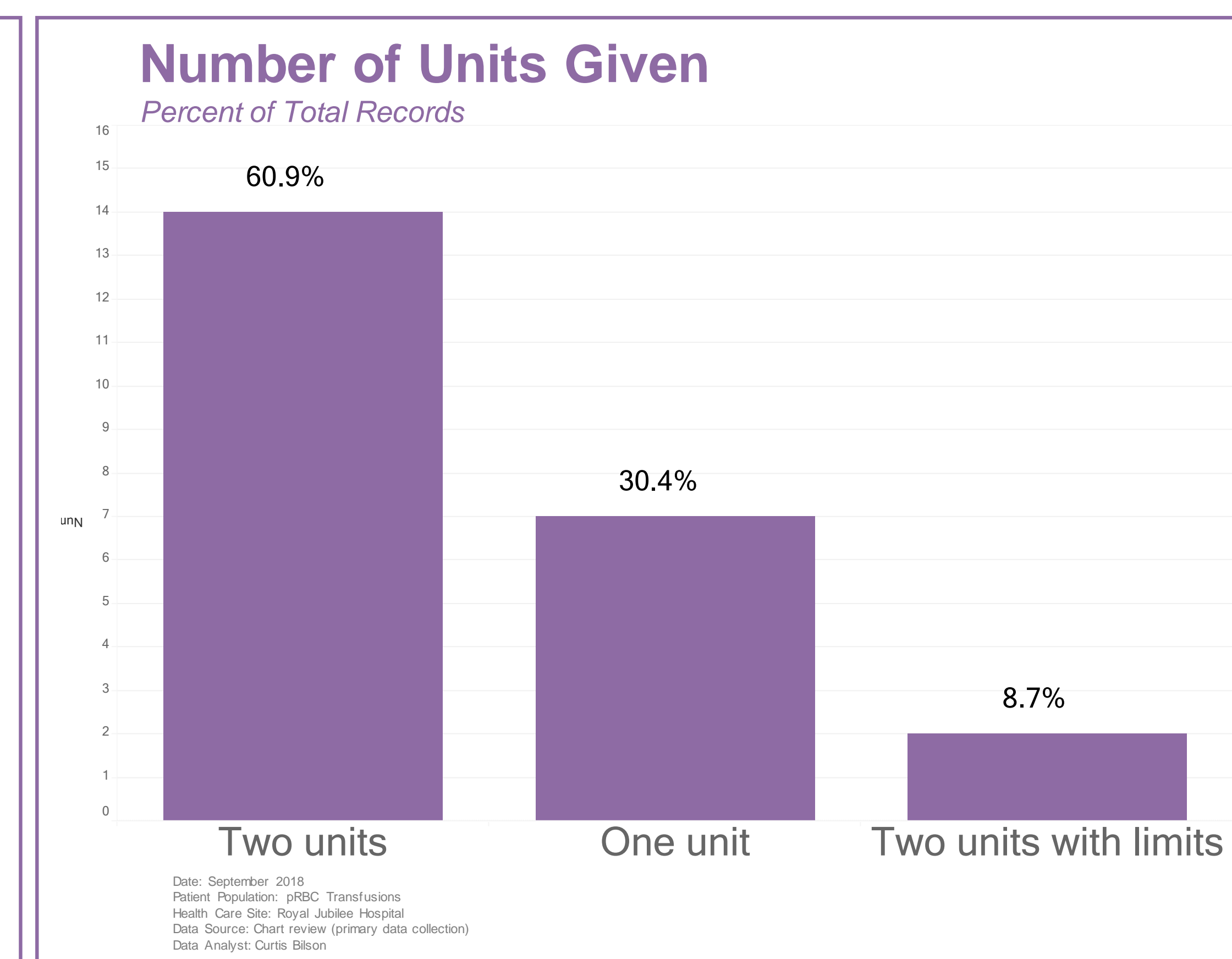
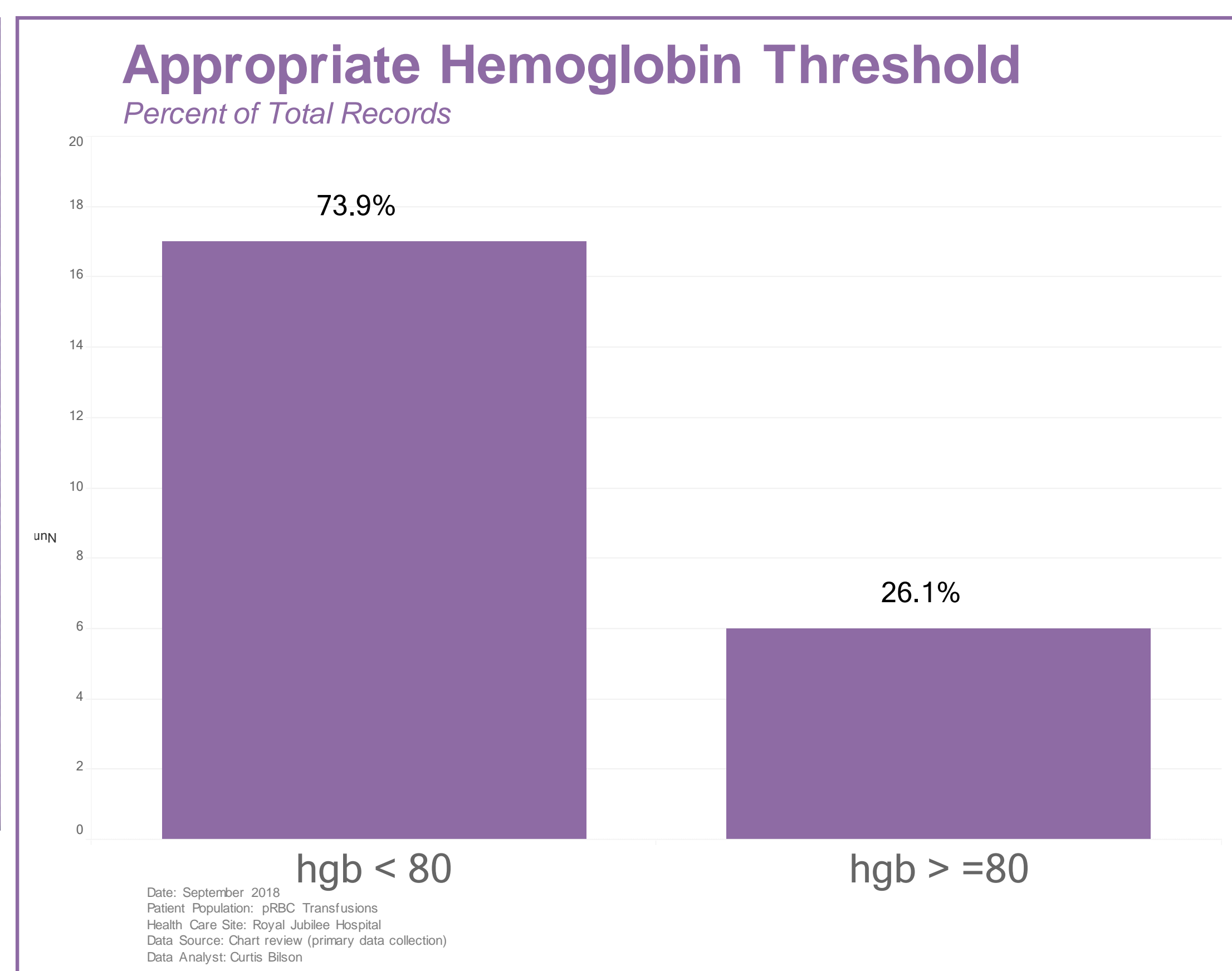
73.9% of prescriptions may be inappropriately prescribed.



AIM STATEMENT

To reduce unnecessary harm by improving appropriate red blood cell (RBC) transfusions by creating a process for privileging and mentoring NPs that will support appropriate blood prescribing. To have 100% of NPs prescribing blood products privileged within 6 months of initiation of the process. To have 100% of NPs new to prescribing blood complete mentorship process within 6 months of privileging.

DATA ANALYSIS



PROBLEM

- Education for physicians and NPs prescribing blood is not standardized
- There has been no data gathered to confirm or evaluate inappropriate prescribing
- The privileging requirements for NPs prescribing blood and blood products has not been determined.

CHANGE IDEAS

- Set 'NP Transfusion Boot Camp' as NP privileging requirement
- Implement mentorship program for NPs new to prescribing blood and blood products.

PDSA CYCLES

- PDSA #1 - Privileging requirements**
 - Implement education requirement
 - Measure number of NPs who have completed process
- PDSA #2 - Mentorship program**
 - Implement mentorship program
 - Measure number of NPs who have completed process
 - Measure appropriateness of NP prescribing through post mentorship prescribing practice assessment

CONCLUSION

The Division of NPs will standardize education requirements for privileging NPs to prescribe blood products and implement a mentorship program for new NP prescribers. Chart review findings reveal current state practice among physician RBC prescribers does not reflect *Choosing Wisely* recommendations. In order to evaluate NP practice more rigorously than physician practice, NPs' RBC prescribing patterns will be evaluated through the first year of practice against *Choosing Wisely* recommendations to evaluate the effectiveness of the change ideas.