PHYSICIAN QUALITY IMPROVEMENT COHORT 10

Project Summaries

2025 – 2026

PQI PHYSICIAN QUALITY IMPROVEMENT Specialist Services Committee | island health

Overview

The Physician Quality Improvement (PQI) program is a collaboration between Island Health and the Specialist Services Committee of Doctors of BC. PQI offers a range of training and education opportunities that all work to build medical staff capacity to participate in and lead quality improvement.

The PQI Program is led by the PQI Joint Steering Committee, which consists of four major key partner groups: clinically active physicians, patient partners, Island Health representatives and Specialist Services Committee representatives. This committee is responsible for setting and supervising the strategic direction of the PQI Program.

PQI Cohort training is a one-year program in which QI skills are developed through learning action projects. The application process is competitive and guided by the Island Health PQI Steering Committee. Medical staff accepted to the program work closely with the PQI team of physician faculty and support staff.

Cohort 10 began the program in September 2025. In October 2026, 16 medical staff and 2 Island Health Directors (dyad partners) graduated from Island Health PQI Cohort 10. This is a summary of their achievements.

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Project Summary

Name & Specialty	Location	Project Aim
Dr. Sameen Ahmed Family Practitioner – Rural Health Project Link	Campbell River/Quadra Island	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.
Dr. Jeff Bishop, Dr. Elspeth McGregor & Tyler Bevan Pediatric Emergency Medicine; Neonatology; Access and Flow Project Link	Victoria	By January 2027, increase the proportion of pediatric and neonatal (0–2 years) 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.
Dr. Fraser Black Family Practitioner – Palliative Care Project Link	Victoria	By July 2026, 25 people residing at Mount Edward Court (a 75-person Cool Aid Society Supportive Housing Site) will have Advanced Care Planning documentation in both their client charts at the housing site and on Cerner PowerChart.
Dr. Sharon Choopa & Dr. Zaneta Lim Pediatricians Project Link	Victoria	By June 1, 2026, the average wait time for patients triaged to be seen within one month at the Nanaimo Pediatric Outpatient Clinic will decrease from 59 days to 31 days.
Dr. Mohammed Sarhan & Dr. Xiaofeng Ding Medical Microbiology Project Link	Victoria	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) from a baseline median of 56% to ≤40%.
Dr. Adrienne Duimering Ophthalmology Project Link	Victoria	By May 2026, in our Victoria-based community ophthalmology practice, we aim to achieve and maintain a 95% retention rate among patients requiring long-term follow-up.
Dr. Karen Johnsson & Dr. Sonja Mathes Family Practitioner; Orthopedic Surgeon Project Link	Victoria	By June 2026, 95% of the Presurgical Resilience and Optimization Program (PROP) patients will complete PROP 4-6 weeks before their surgical date. Our project will include Vancouver Island Joint Replacement patients and PROP will be organized via RebalanceMD.
Dr. John Kim Family Practitioner – Student Wellness Project Link	Victoria	By May 31, 2026, 100% of Non-Urgent Referrals will be completed within 7 days after the visit with Dr. John Kim at the University of Victoria's (UVic) Student Wellness Centre (SWC).

Project Summary

Name & Specialty	Location	Project Aim
Dr. Stephanie Niles & Rebecca McGregor Emergency Medicine; Clinical Operations at Nanaimo General Hospital Project Link	Nanaimo	By June 2026, reduce the average time from triage to a 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 Emergency (NRGH) Department (ED).
Dr. Jill Stone Plastic Surgery Project Link	Nanaimo	By April 2026, increase the number of skin biopsies performed in Dr. Jill Stone's plastic surgery clinic in Nanaimo, by 100%.
Dr. Alison Tedder Plastic Surgery Project Link	Victoria	By June 2026, reduce reported anxiety by 50% in paediatric dental surgery population in Saanich Peninsula Hospital (SPH).

IMPROVING HEPATITIS C VIRUS IDENTIFICATION AMONG STRUCTURALLY VULNERABLE PEOPLE IN CAMPBELL RIVER

Physician Lead:	Dr. Sameen Ahmed
Location:	Campbell River
Specialty:	Family Medicine

Background:

The hepatitis C virus (HCV) epidemic is a public health problem worldwide (AJPM 2023). Within British Columbia (BC), about 60 000 people have been exposed to HCV and there are about 2000 new cases per year (BCCfE, 2022). Untreated HCV infection can lead to liver cirrhosis, liver failure, and liver cancer which are associated with high morbidity and mortality and involve significant health care costs. Treatment for Hepatitis C is very effective and given by oral medication for a relatively short duration (8-12 weeks) with minimal side effects. Stigma, racism, unemployment, unstable housing, poverty, and patient-provider knowledge gaps result in reduced access to HCV care (BCMJ, 2021). The BC Center for Disease Control (BCCDC) recommends annual testing for those at continued risk of infection with HCV (BCCDC Hepatitis C). Testing for HCV is the first step to gaining access to highly effective life-saving and health system cost-saving treatment.

Problem:

The volume, acuity, and complexity of competing healthcare needs experienced by patients served by the Campbell River Outreach team often result in clinicians overlooking annual HCV screening. Currently, only 55% of eligible patients seen by participating Campbell River Outreach team clinicians had received their annual HCV antibody screening test. The team serves a population largely consistent with that defined by the BCCDC as "high risk" for HCV infection (BCCDC Hepatitis C), including people who are unstably housed and/or inject drugs and/or are Indigenous and/or have spent time in corrections facilities. Without improving testing rates, access to effective treatment for people infected with HCV is compromised.

Patient Engagement:

Our patient partner was identified late in the project timeline by the PQI team. He joined our operational team meetings and his lived experience was instrumental in developing and helping design our second change idea in a way that resonated with our patient population. This included the choice of placing the sign behind bathroom stall doors to respect privacy and prevent stigma. This was in collaboration with one of our key community partners who joined the project at the same time. Some of the activities included consulting with patients on site to see if the early drafts of the education poster resonated with them and making edits accordingly to produce the final poster.

Aim of Project:

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.

Measures:

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(s)

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

Balancing Measure(s)

- 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

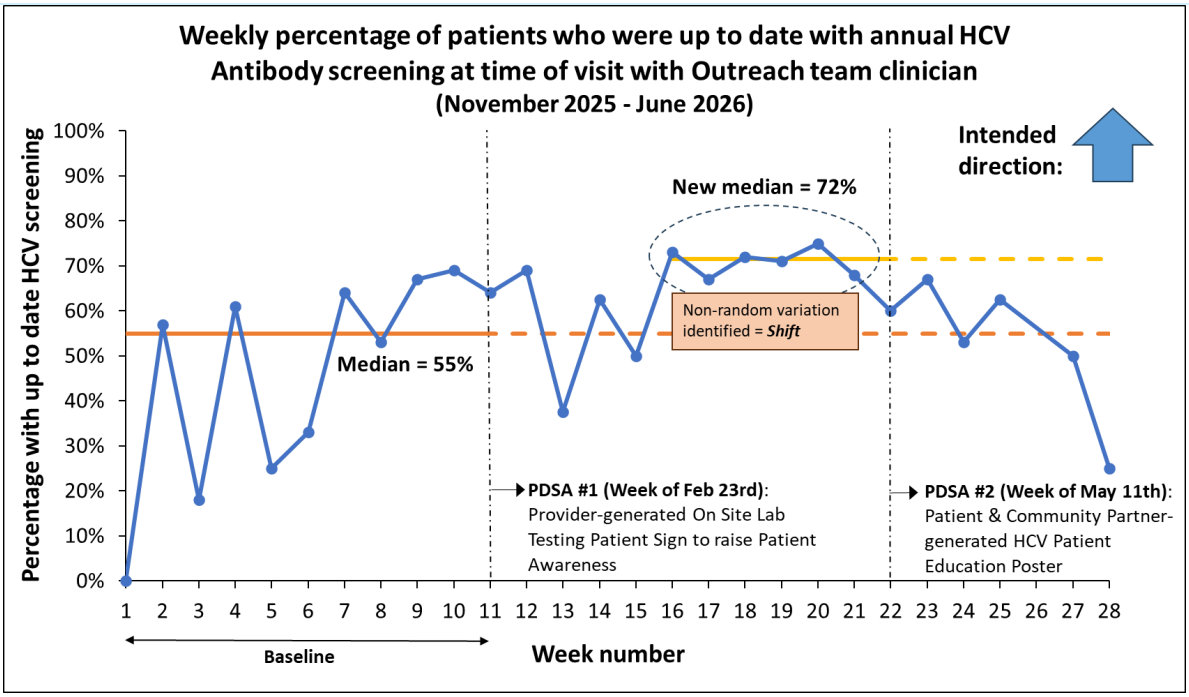
Action Taken:

In PDSA #1, signs advertising on-site physician, nurse and laboratory testing availability were posted in a high traffic area at participating Outreach sites to help raise patient awareness about these services. In PDSA #2, a patient education poster was created by our patient partner and community partner to be posted on the back of bathroom stall doors in participating community facilities where Outreach team patients are seen.

- **PDSA #1**: ***Provider-generated On Site Lab Testing Sign to raise Patient Awareness***
    - A laminated bright green sign stating "Doctor/Nurse On Site Testing/Screening Available Today" was created and placed at conspicuous locations at two sites to raise patient awareness about community-based lab testing availability.
- **PDSA #2: *Patient & Community Partner-generated HCV Patient Education Poster***
    - A laminated community and patient partner-designed poster was created to improve patient education regarding HCV risk factors, treatment safety, and testing and treatment availability. It was posted on the back of bathroom stall doors at two sites.

Data Analysis:

Baseline data was skewed by variation in number of weekly patient encounters. Results showed improvement from 55% at baseline to 72% with PDSA #1. PDSA #2 was impacted by a new initiative within our team that pulled providers away. It is not felt that enough data was collected to accurately assess this change idea. Overall, the data from PDSA #1 is encouraging and provides confidence that raising patient awareness and education is a helpful strategy with our patient population.



Lessons Learned:

- **Lesson #1:** Clinicians whose work is more mobile in nature (outside a traditional clinic setting) do not find laminated signs useful for raising awareness in their patient population and work setting.
- **Lesson #2:** Patient partner and community partner involvement at monthly Outreach team meetings sped up the process of creating and modifying a change idea in a way that resonated with the patients who access our services.
- **Lesson #3:** Data collection was challenging with some clinicians spending extra time beyond their regular work day to collect data. One clinician discontinued involvement in this aspect of the project due to the impact on patient contact time. The launch of a new initiative at the start of PDSA #2 and vacation leaves significantly impacted the volume of data collected.
- **Lesson #4:** Some providers increased patient testing for other recommended screening tests due to their QI project involvement.
- **Lesson #5:** Outreach team engagement in QI work strengthened relationships among team members through centering around a common challenge and working together to address it through collaborative change idea generation, selection and testing.
- **Lesson #6:** Cerner could be a very useful, shared documentation and communication tool to aid patient care for a highly mobile population who seeks care in a variety of settings. However, administrative access barriers to documenting in patient charts in Cerner exist for some clinicians.

Next Steps:

- **Next Step #1:** Work together with the diverse team we have built to develop a change idea to increase HCV Ab testing that works better for mobile Outreach clinicians.
- **Next Step #2:** Continue to collect data at sites where the patient/community partner bathroom sign is posted to better assess this change idea.

IMPROVING PEDIATRIC AND NEONATAL TRANSPORT SAFETY THROUGH STANDARDIZED ESCORT TRAINING

Physician Lead:	Dr. Jeff Bishop, Dr. Elspeth McGregor, Tyler Bevan (RN)
Location:	Nanaimo and Victoria
Specialty:	Pediatrics, Neonatology, Transport

Pediatric and neonatal patients in British Columbia requiring interfacility transfer are assigned transport teams based on care requirements, ranging from Emergency Medical Responder (EMR) to Critical Care Paramedics (CCP), including the specialized Infant Transport Team (ITT). Historically, ITT has managed most neonatal and pediatric critical care transports.

When ITT is unavailable, sending centres are required to provide a nurse or physician escort, often without formal training in transport medicine. Increasing demand for transport, combined with limited ITT capacity, has led to delays and greater reliance on these ad hoc escorts. Provincial guidance has identified the need to expand local capacity for low-acuity perinatal transport. This represents an opportunity to improve safety, standardize care, and strengthen system efficiency across both pediatric and neonatal populations.

Problem:

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.

Aim of Project:

By January 2027, increase the proportion of pediatric and neonatal (0–2 years) 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.

Measures:

Outcome Measure

- Proportion (%) of pediatric (0–2 years) and neonatal interfacility transports completed by trained transport-certified nurses (NEOSTAR/PEDI-CERT).

Process Measure(s)

- 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 used appropriately

Balancing Measure(s)

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

Action Taken:

This quality improvement initiative is being conducted across Island Health and involves pediatric, neonatal, transport, and operational leadership teams. The project is currently in a pre-implementation phase, focused on building the infrastructure required for a sustainable and scalable transport model.

Phase 1: Design and Implementation Readiness
To date, efforts have focused on developing a standardized approach to pediatric and neonatal transport. This has included a jurisdictional scan to identify best practices in transport medicine, as well as collaboration with Professional Practice to define appropriate training, competencies, and scope for specialty-trained nurses.

Engagement activities have included identifying and recruiting interested nursing staff, developing training frameworks aligned with provincial standards, and working with operational leaders to ensure the model is feasible, appropriately resourced, and can be operationally owned by the CERT program.

In parallel, processes for data collection, outcome tracking, and post-transport feedback have been developed to support future evaluation.

Phase 2: Planned Implementation and Testing
Funding has been secured to support implementation and executive leadership approval obtained to train nurses. Key operational processes have been developed: staffing models, dispatch criteria, workflows for transport assignment, and a training schedule and curriculum.

Our next steps include training roll-out in Autumn 2026, equipment securement, and ambulance orientation. Our aim is for team roll-out in early 2027.

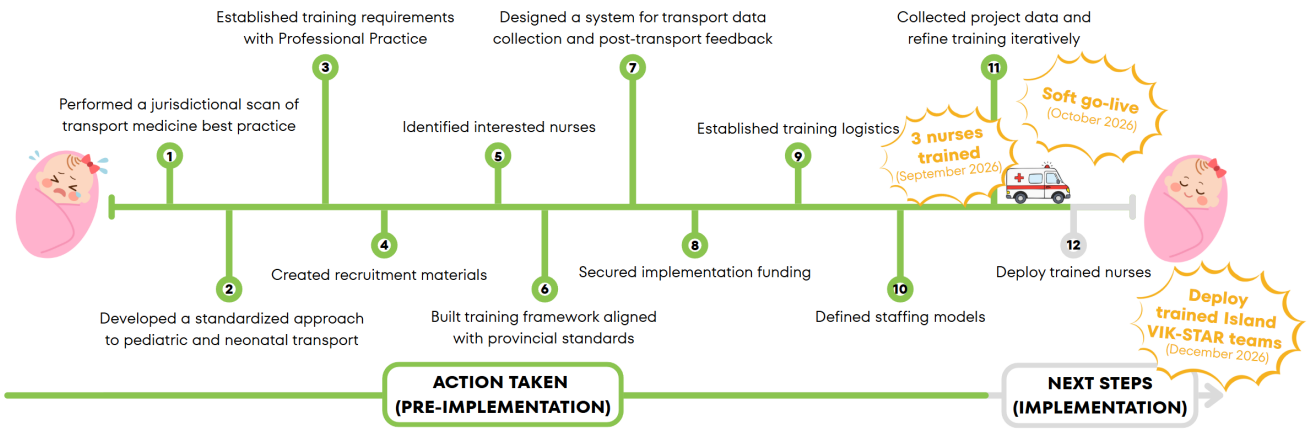
Upon roll-out, PDSA cycles will focus on pilot training of transport-certified nurses, initial use in low- to moderate-acuity transports, and iterative refinement of training, dispatch, and workflow processes based on real-world experience.

Data Analysis:

Baseline assessment demonstrated that the majority of pediatric and neonatal transports requiring escort are currently completed by ad hoc teams without standardized training.

At this stage, no data is available for the measures identified, as operational approvals and processes for education are still being finalized. Initial data collection processes and outcome measures have been established to support future evaluation following pilot implementation (see **Figure 1**, step 11).

Figure 1. Pediatric and Neonatal Transport Safety Project Road Map



Lessons Learned:

- **Sustainable change requires early operational alignment:** Significant time and effort were needed to engage leadership, secure funding, and ensure the model could be operationalized and owned by the transport program.
- **Standardization is challenging in the absence of clear evidence:** Limited published guidance on pediatric and neonatal transport required a jurisdictional scan and multidisciplinary collaboration to define best practices and training requirements.
- **Pre-implementation work is critical for success:** Developing training frameworks, identifying interested staff, and establishing data collection processes were essential steps to enable safe and scalable implementation.

Next Steps:

- Finalize operational processes to support implementation, including scheduling and delivery of training, coordination of simulation and supervised CERT shifts, and development of dispatch criteria and staffing models for transport-trained nurses.
- Initiate Phase 1 pilot implementation, including training of the initial RN cohort and launch of early PDSA cycles to evaluate feasibility, transport utilization, and workflow processes.

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

Physician Lead:	Dr. Fraser Black
Location:	Victoria
Specialty:	Family Medicine – Palliative Care

Background:

Advanced Care Planning (ACP) empowers people to express their values and care preferences before a health crisis. In British Columbia, ACP conversations can also include identifying preferred substitute decision-makers (including Representation Agreements) and documenting end of life and after-death wishes (funeral, cultural practices, disposition of belongings) to ensure preferences are respected. A public opinion poll found that while 79% of British Columbians agreed that it's important to talk about what matters most for future health care, only 10% had had a conversation with a healthcare provider.

For people who are marginalized such as those experiencing homelessness, living in poverty and those facing stigma and discrimination, ACP is especially important but often inaccessible because of complex legal-medical jargon, a lack of digital and physical access to documents, and a justified mistrust due to systemic discrimination which prevents safe, equitable engagement with healthcare systems and providers.

Problem:

People living in supportive housing such as those provided by Cool Aid often face additional barriers that prevent ACP conversations from happening. Only one resident out of 75 at one Cool Aid housing site (Mount Edward Court) had a documented ACP in place. Barriers to ACP conversations include poverty, homelessness, discrimination and a history of trauma with the medical and other colonial systems. At Cool Aid housing sites, staff and clinicians see how serious illness often takes away the little control residents may have. Residents often die away from their communities, with decisions made for them by people who they would prefer not to make decisions for them, and without their end of life and after-death wishes known.

Patient Engagement:

Tony Patriarche, a resident at Mount Ed Supportive Housing site, joined the project and provided ongoing suggestions, supported communication strategies to align with residents at Mount Ed, provided input around change ideas such as the ACP Info/Planning Sessions and ACP package distribution and participated directly in ACP events.

"*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 Patriarche (Patient Partner)

Aim of Project:

To increase Advanced Care Planning documentation at Mount Edward 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.

Measures:

Outcome Measure

- # of ACP documents in Mount Ed in Client Folders
- # of ACP documentations in Island Health Cerner/PowerChart

Process Measure(s)

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

Balancing Measure(s)

- Work is - Worthwhile/Satisfying/Meaningful to me (Likert Scales) for staff (Appendix A)
- Confidence that people's healthcare wishes/preferences would be honoured and confidence in being able to have ACP conversations (Likert Scales) (Appendix A)

Action Taken:

Mount Edward Court is a CoolAid supportive Housing site primarily for seniors. About 75 people live at this site and there are about 15 regular housing staff that work there.

- **PDSA #1 – Offer group ACP Info/Planning Sessions for Residents ("Come for the pizza – stay for the planning sessions" (ADAPT)**
  - Fifteen in-person, drop-in, group sessions held (~10 attendees per session)
  - Five 1-1 sessions were also offered in addition ('ACP Clinics')
- **PDSA #2 - Formal education session on Advanced Care Planning offered to Mount Ed Staff (ADAPT)**
  - Initial plan was to hold a series of sessions but feedback after the first led to an adaption to a more informal approach to educating and engaging staff
  - Informal engagements totalled 61 interactions around ACP with staff during project
- **PDSA #3 - ACP packages delivered to residents and 'Question Boxes' added to common areas (ADAPT)**
  - Broader engagement across Mt Ed where ACP packages were delivered to all residents to read and complete on their own
  - Anonymous 'Question Boxes' (opportunity to submit questions from staff or residents to 'the ACP box' that they may have about ACP) was abandoned as part of the change idea
- **PDSA #4 - Coaching patient's primary care providers (ADOPT)**
  - Seven primary care providers were identified as having attached patients at Mt Ed
  - Direct engagement including 1-1 coaching and sharing of ACP documentation process and instructions

Data Analysis:

During this project, there were:

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

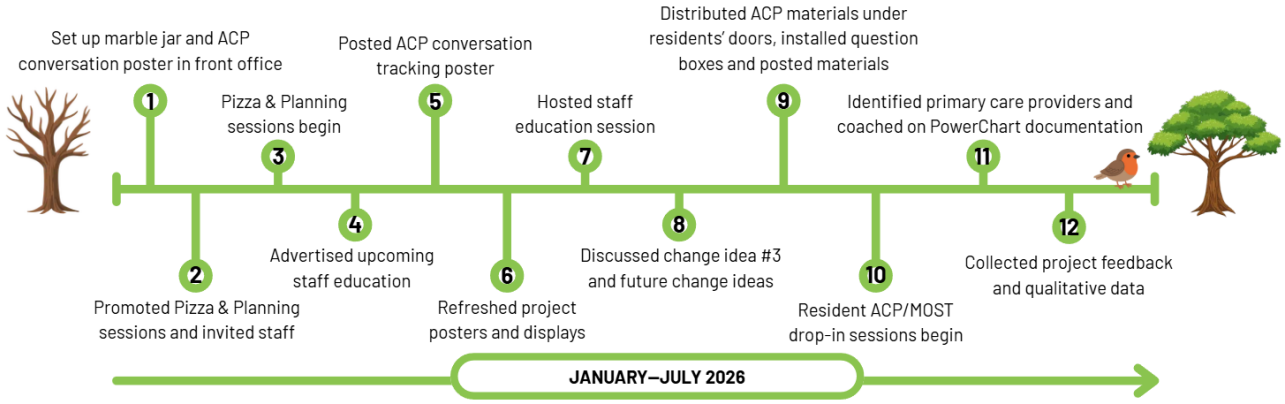
14 **ACPs documented** in Cerner PowerChart

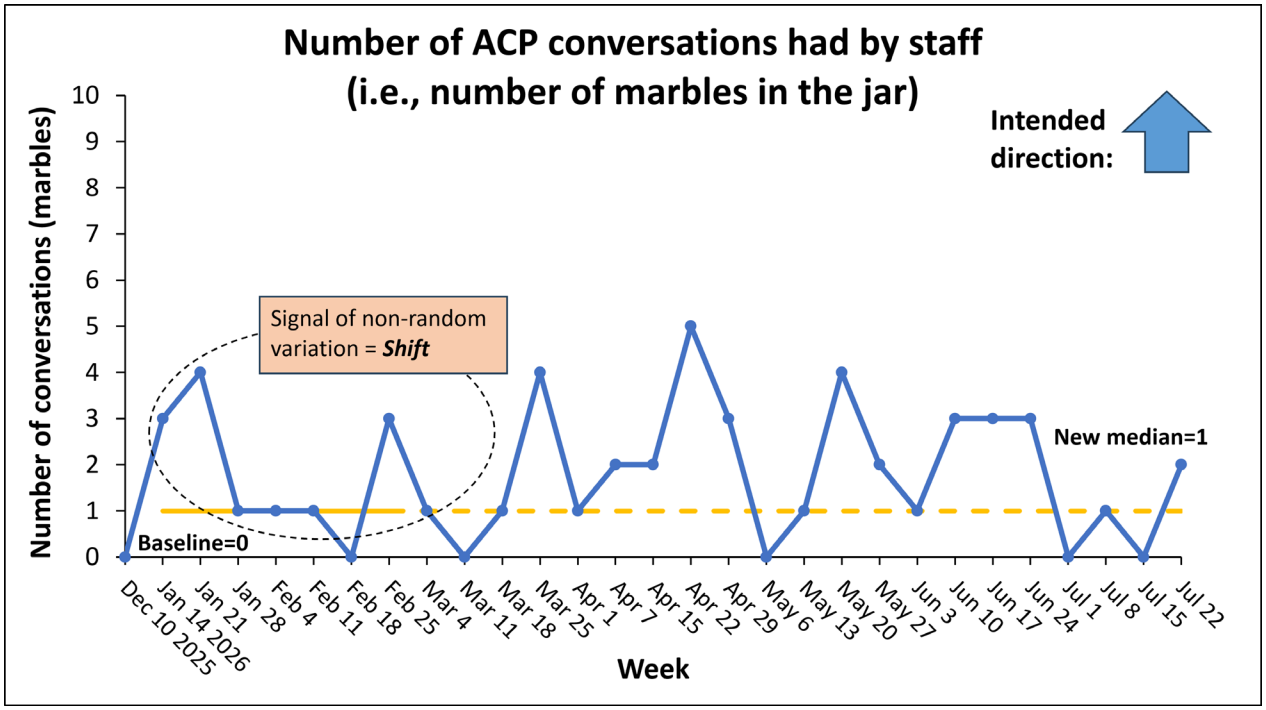
There were also:

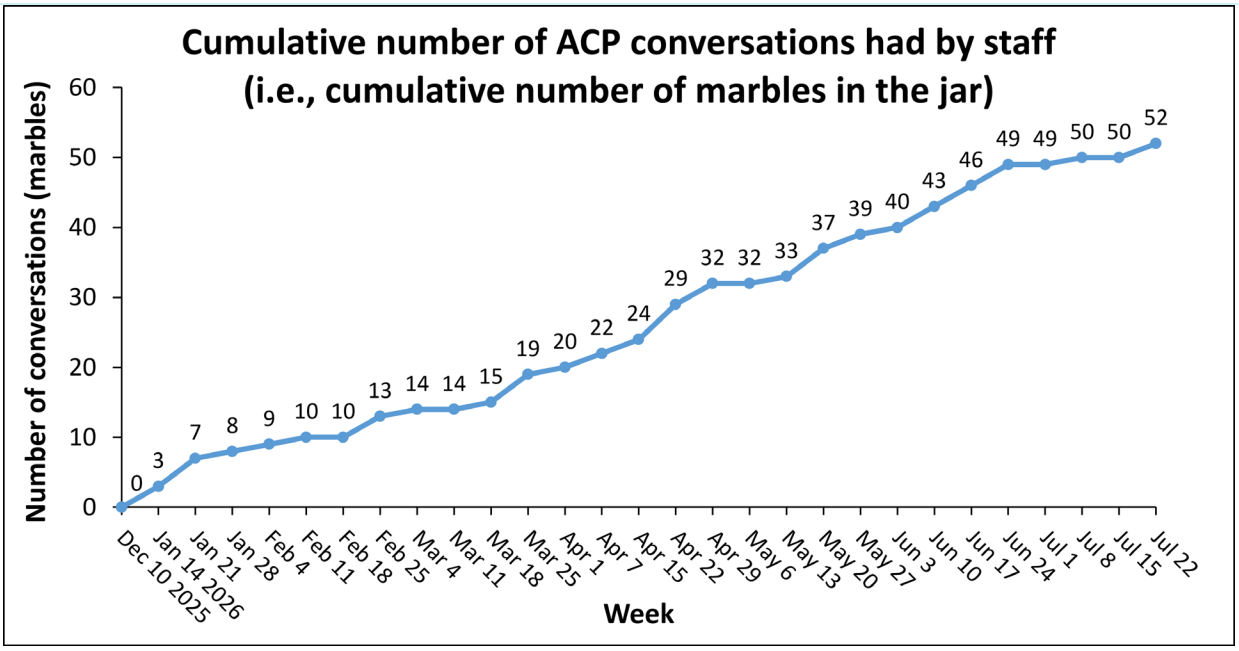
10 Pizza & Planning sessions | **5** ACP/MOST drop-in sessions | **109** clients attended ACP sessions *(total attendance)* | **52** ACP marble conversations

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

Project Actions and Timeline:







Lessons Learned:

1. Demand and engagement - Residents wanted ACP conversations; sessions were well received and sparked rich discussion.
2. Access and space – Few places exist to ask ACP questions, especially for those without primary care providers.
3. Time and continuity – ACP requires ongoing presence; recurrent sessions enabled uptake more than one-off events
4. Conversation versus completion – Many are willing to talk about wishes but less able or comfortable completing ACP documents
5. Visibility and workflow – Simple interventions (slipping ACP tools under doors) raised awareness; training primary care providers to enter ACP info into the Cerner Powerform was essential
6. Relationships and capacity – Trusted staff are best positioned to lead ACP but may lack time, training, or bandwidth; introducing projects into overstretched workplaces creates tension. Staff stated that they preferred less formal opportunities to hear more about having ACP conversations
7. Lived experience and sustainability – A patient partner from Mount Ed Court provided crucial insight and supports for future sustainability.

Next Steps:

- Focus groups planned for post-data collection with Mt. Ed Staff, Patient Partner and QI team to explore sustainability and possible spread of the project.
- Based on this work, a CIHR grant application has been submitted and is pending approval to support further research and quality improvement in this area.

DOWN: DECREASE OUTPATIENT WAIT-TIMES IN NANAIMO FOR URGENT PEDIATRIC PATIENTS

Physician Lead:	Dr. Zaneta Lim and Dr. Sharon Choopa
Location:	Nanaimo
Specialty:	General Paediatrics

Background:

Long wait times for specialist care are a recognized, worsening problem across British Columbia's health system, not unique to paediatrics or to Nanaimo. In the Fraser Institute's 2025 Waiting Your Turn report, BC's overall wait time from GP referral to treatment reached 32.2 weeks in 2025 — the second-longest in Canada, and longer than in 2024 — while patients nationally wait roughly 4.5 weeks beyond what physicians consider clinically reasonable after a specialist consultation. Paediatrics faces its own version of this pressure: Government of Canada labour-market projections identify paediatricians as facing a "strong risk of labour shortage" nationally through 2033, driven in part by an aging workforce (35% of Canadian paediatricians are 50 or older, with a median retirement age of 66). Locally, rising referral volumes against a fixed physician complement reflect this same demand-capacity gap, making timely access to a small group of specialists an increasingly systemic, not just local, challenge.

Problem:

Referrals to the Nanaimo Paediatric Central Intake average ~125 per month over the last 2 years, with 7 full-time paediatricians seeing an average of 54 new referrals per month. Wait times across all 4 triage categories (1, 3, 6, and 12 months) have nearly doubled over the past year. As a result, referrals triaged to be seen within 31 days are, on average, being seen at 59 days — nearly double the intended target.

Patient Engagement:

Patient and family partners were not formally engaged in this project cycle. A family/community experience survey (aligned with the Driver Diagram's Family and Community Awareness drivers) is planned for future cycles.

Aim of Project:

Decrease average wait times for pediatric outpatient one-month referrals triaged to be seen from 59 days to 31 days by June 1, 2026.

Measures:

Outcome Measure

- Average wait time to be seen by a pediatrician.

Process Measure(s)

- Number of new referrals triaged to be seen by 1 month – booked per month.

Balancing Measure(s)

- Wait time for referrals to be seen by 3 months

Action Taken:

- This project covers referrals triaged for a one-month appointment across the Nanaimo Paediatric Central Intake (7 full-time paediatricians), monitored using data pulled from Accuro EMR by the Central Intake data team.
- In December 2025, the team increased the percentage of clinic appointments reserved for referrals triaged to be seen within 1 month (Physician Capacity driver → Clinic Demand and Capacity secondary driver, per the Driver Diagram). Status: adopted — wait times have trended down since this change, with 4 consecutive months (Mar–Jun 2026) below the baseline median.

Data Analysis:

Figure 1:

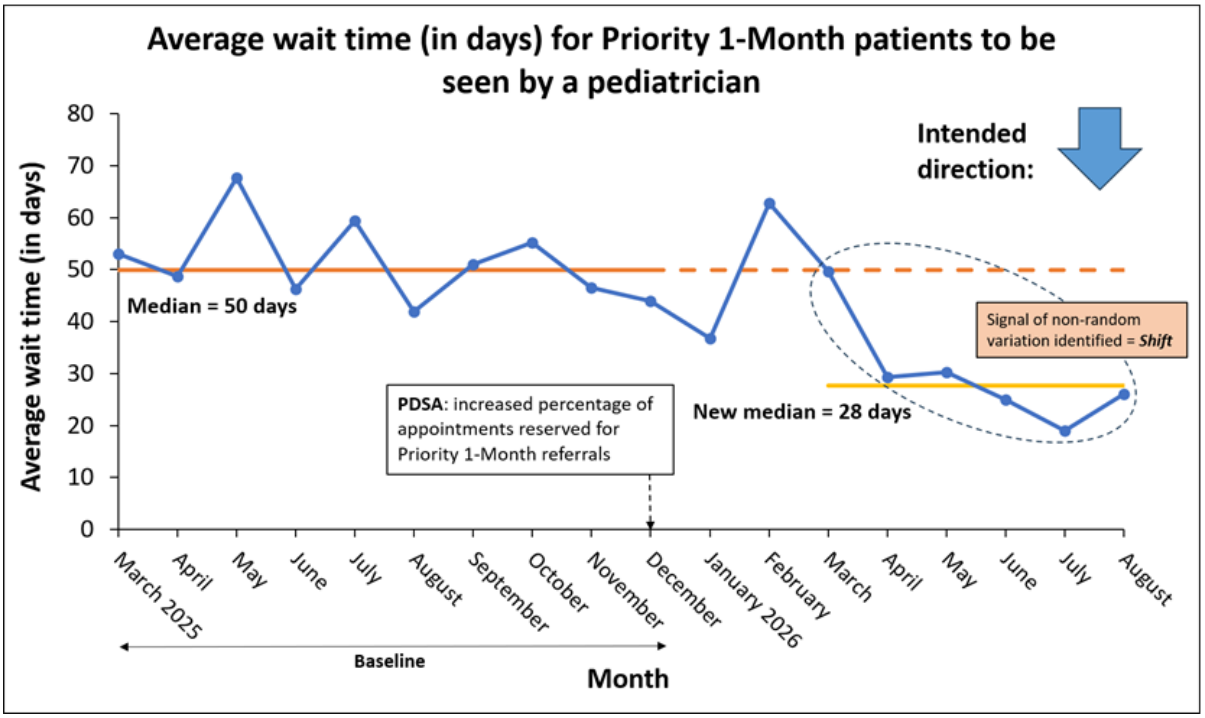
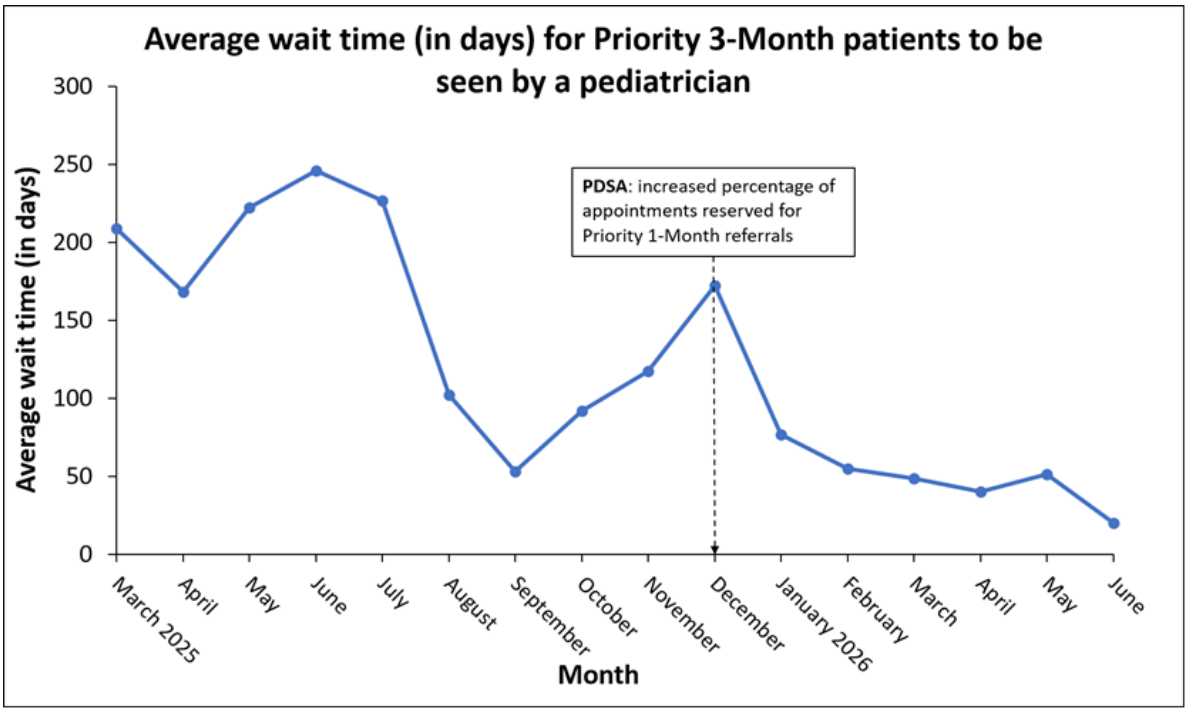


Figure 2:



Lessons Learned:

- The December 2025 increase in appointments reserved for <1-month referrals (Physician Capacity driver) coincide with a true shift in wait times from March–August 2026.
- 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.
- The process measure (bookings/month for 1-month referrals) has formally met the 31-day goal and the 6-point run-chart Shift rule.
- Towards the end of our project, it became obvious that the original balancing measure of wait time for referrals to be seen by 1 year (Baseline average = 555 days) was not reasonable given that our project duration of 6months to 1 year was much shorter than the actual measurement duration.
- The PQI structure allowed us to quickly pivot to measuring wait time for referrals to be seen by 3 months instead and we now have the tools built into our EMR to continue measuring wait times for referrals to be seen at 1 year after this project formally ends.
- Patient and family partners were not engaged in this project cycle, limiting insight into the lived experience of the wait times being addressed.

Next Steps:

- Formalize the December 2025 capacity change as standard practice and design a family/community experience survey per the Driver Diagram.

REDUCING LOW-VALUE FOLLOW-UP BLOOD CULTURES IN GRAM-NEGATIVE BACTEREMIA AT ROYAL JUBILEE HOSPITAL

Physician Leads:	Dr. Mohammed Sarhan, Dr. Xiaofeng Ding
Location:	Victoria
Specialty:	Medical Microbiology

Background:

Current evidence indicates that follow-up blood cultures (FUBC) in Gram-negative bacteremia (GNB) have low diagnostic yield, with approximately 95% returning negative results. Routine FUBC are not recommended in uncomplicated cases and should be reserved for selected high-risk patients.

The clinical benefit of FUBC remains uncertain, with studies showing no clear reduction in mortality and potential confounding in those suggesting benefit. At the same time, repeat blood cultures are associated with increased hospital length of stay (LOS), greater antimicrobial exposure, and higher healthcare costs.

Despite this, FUBC continue to be frequently ordered without clear clinical indication. This highlights an opportunity to improve diagnostic stewardship, reduce unnecessary interventions, and optimize patient flow and resource utilization.

Problem:

At Royal Jubilee Hospital (RJH), more than 50% of patients with Gram-negative bacteremia (GNB) undergo follow-up blood cultures (FUBC) despite limited clinical indications. Local data indicate that approximately 95% of these cultures are negative, and with an estimated cost of $100 per test, FUBC for GNB have contributed approximately $300,000 in laboratory costs since 2023, in addition to potential downstream resource use such as increased length of stay (LOS) and antibiotic exposure. This reflects a gap between current practice and evidence-based recommendations.

Patient Engagement:

A patient partner with a background as a retired medical laboratory technologist was engaged to provide perspective on the patient experience and laboratory processes. The patient partner highlighted that patients are often unaware of the purpose of blood tests being performed, which limits their ability to question or advocate against unnecessary investigations. This perspective emphasized that responsibility for appropriate test ordering rests primarily with the ordering physician. The patient partner reinforced the importance of this project, noting its clear benefits in reducing unnecessary testing, improving patient care, and minimizing time and costs within the healthcare system.

Aim of Project:

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) from a baseline median of 56% to ≤40%.

Measures:

Outcome Measure

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

Process Measure(s)

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

Balancing Measure(s)

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

Action Taken:

This project was conducted at RJH and involved ordering physicians across multiple specialties, including Hospitalists, Residents, Internal Medicine, Emergency Medicine, and Critical Care.

- **PDSA #1:** Targeted real-time (in-person or virtual) education was delivered to ordering physicians with higher rates of follow-up blood culture (FUBC) use.
- **PDSA #2:** Standardized comment was added to blood culture results to remind the care team that repeat cultures may not be needed in uncomplicated cases.
- **PDSA #3:** A reminder will appear when a repeat blood culture is ordered within 48 hours on Electronic Health Record (EHR), prompting the care team to reassess whether a repeat culture is clinically necessary in this situation.

Data Analysis:

- Results show improvement in reducing the percentage of follow-up blood cultures from 35% to 15% (Figure 1).
- Targeted engagement with ordering physicians leads to a reduction in follow-up blood cultures across specialty groups to consistently low levels for the past four months. Residents account for the largest share of remaining follow-up orders (Figure 2).
- Over the seven months of PDSA cycles from December 2025 to June 2026, 79 fewer follow-up blood cultures were performed than expected based on the baseline average of 17 follow-ups per month (Figure 2). At an estimated cost of $100 per test, this reduction resulted in approximately $7,900 in cost savings.

Figure 1:

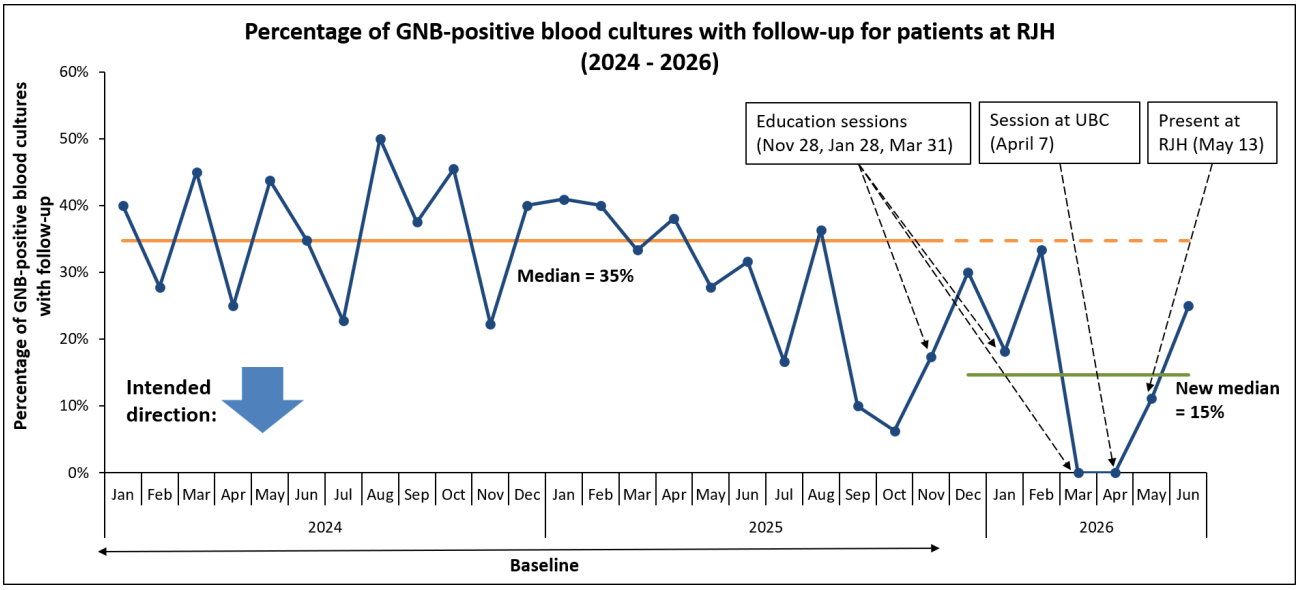
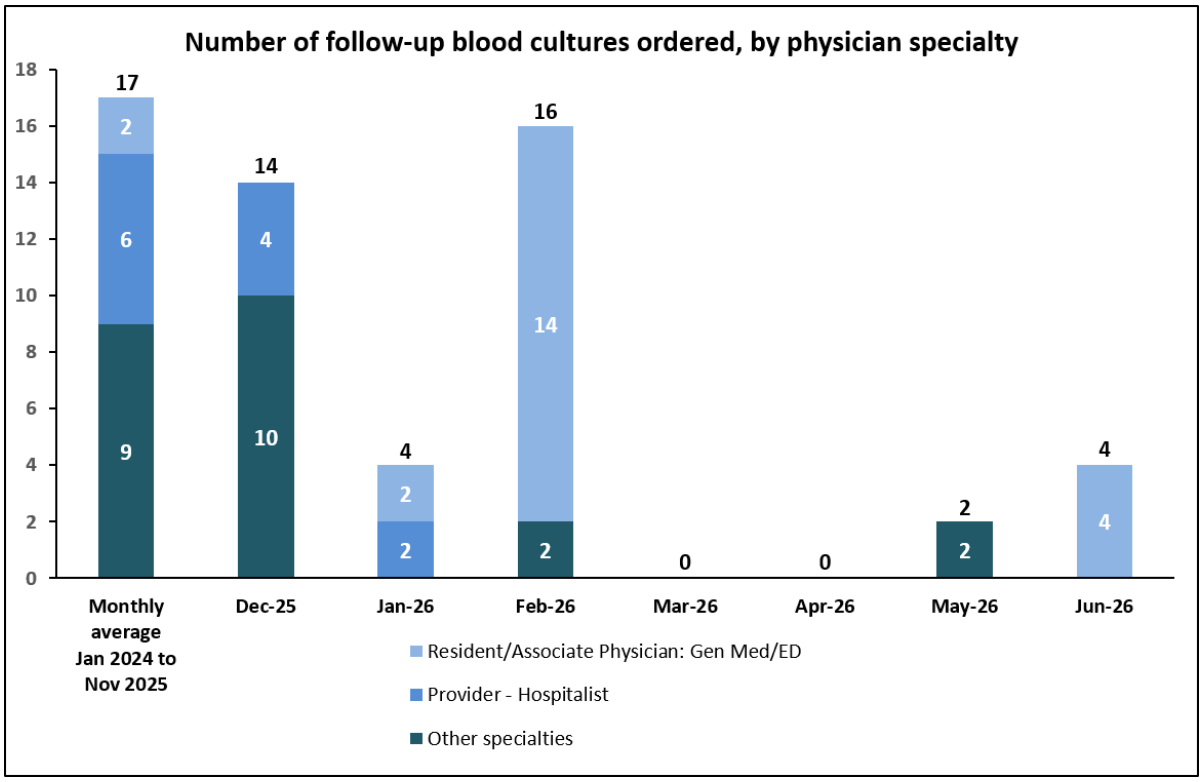


Figure 2:



Lessons Learned:

- **In-person education works best:** Face-to-face, targeted education was more effective than emails because it allowed discussion, answered questions, and built trust.
- **Clinicians need clear evidence:** Providers were more comfortable reducing follow-up blood cultures (FUBC) when they had evidence to support their decisions.
- **Simple reminders help:** Adding comments in the workflow was an easy, well-tolerated way to reduce unnecessary tests without causing alert fatigue.

Next Steps:

- Operationalize ongoing education sessions for evidence-based lab ordering best practices.
- Implement an Electronic Health Record (EHR) alert to reduce repeat blood cultures across all patient populations, reinforcing appropriate and evidence-based test ordering.
- Spread education beyond Gram-negative bacteremia and beyond Royal Jubilee Hospital to support sustained behaviour change and reduce unnecessary testing and resource use.

IMPROVING CONTINUITY OF CARE FOR OPHTHALMOLOGY PATIENTS

Physician Lead:	Adrienne Duimering
Location:	Victoria
Specialty:	Ophthalmology

Background:

In a general ophthalmology practice, a significant proportion of patients require long-term follow-up care. Common conditions necessitating ongoing review every 6–12 months include glaucoma, macular degeneration, and diabetic retinopathy. When these patients are lost to follow-up, they are at risk of presenting later with progressive disease, often requiring more intensive treatment and carrying a poorer prognosis.

Loss to follow-up places additional strain on the healthcare system—either through the need for re-referral by another healthcare provider or by reducing access for other patients when appointments are missed.

Problem:

Our community ophthalmology clinic in Victoria has made several attempts to improve follow-up care. Initially, follow-up appointments were booked at the time of consultation, leading to long front-desk wait times, high no-show rates, and frequent rescheduling.

We then shifted to booking one month before the follow-up date with automated recall notices — but this overwhelmed phone lines, delaying care for more urgent patients.

Introducing an online booking system with email reminders seemed promising, yet only one-third of patients booked successfully, leaving two-thirds lost to follow-up until the problem was identified.

Patient Engagement:

- As part of our improvement efforts, we sought patient input to understand experience. An optional feedback prompt on the online booking form showed that patients using the system valued its ease of use; however, this data was subject to self-selection bias, as only those who successfully booked online provided feedback.
- To capture broader input, a 3-point smile-scale survey was placed on an iPad in the waiting room. Results indicated patients remained overall satisfied with their clinic experience throughout the changes.

Aim of Project:

In our Victoria-based community ophthalmology practice, we aim to achieve and maintain a 95% retention rate among patients requiring long-term follow-up within 6 months.

Measures:

Outcome Measure

- % of patients retained each month
    - Defined by:
        - number of patients seen in follow-up within 6 months of when they are due/total number of patients due for follow-up that month
    - Data collected from EMR monthly

Process Measure(s)

- % pts online booking
    - number of patients booking online /
    - total number of patients booked that month
- Binary (y/n) equal distribution of phone calls between all staff members within the allotted 1-week timeframe completed during working hours (to demonstrate project sustainability)

Balancing Measure(s)

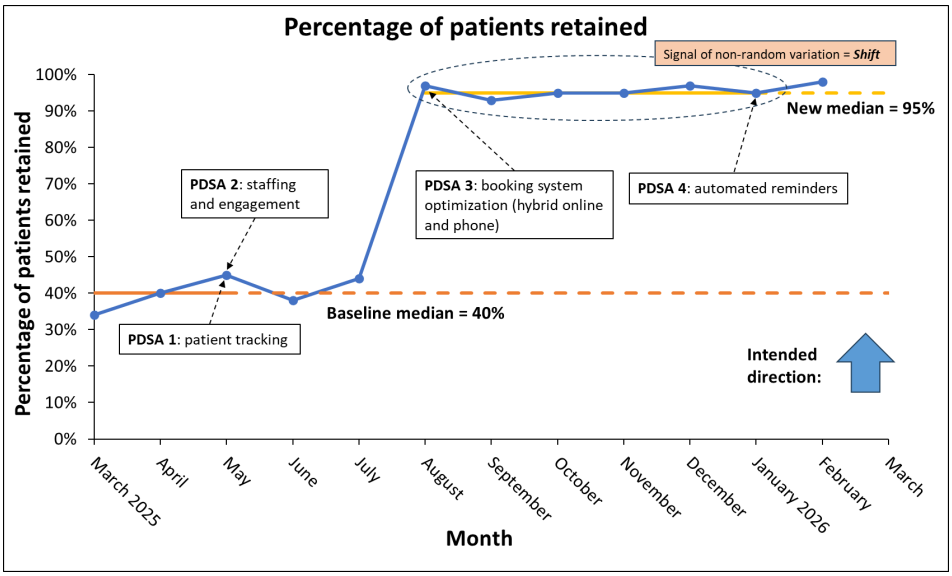
- Staff satisfaction
    - Measured indirectly by staff attendance (as supported by anonymous interviews conducted by external consultant)
    - Anonymized attendance tracked daily
- Patient satisfaction
    - 3-point smile scale iPad waiting room

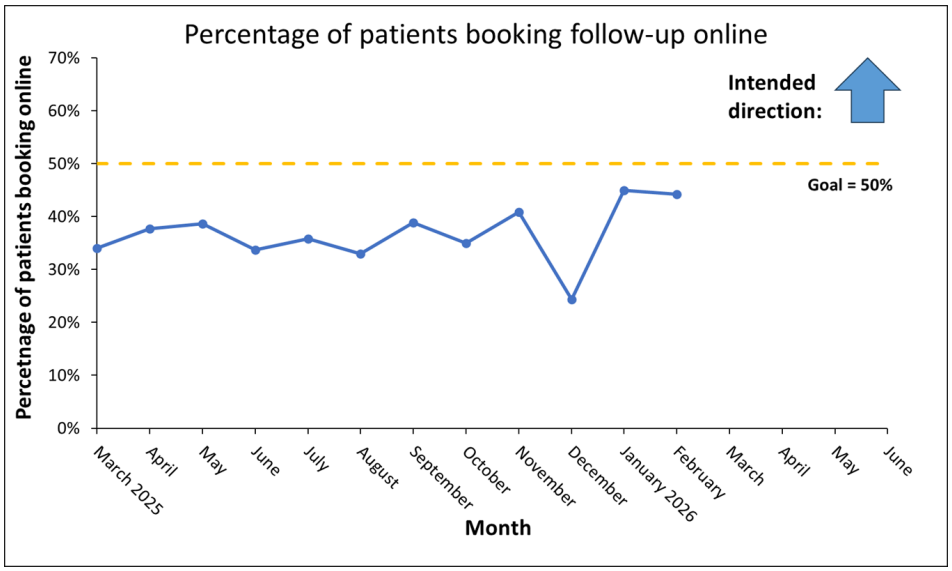
Action Taken:

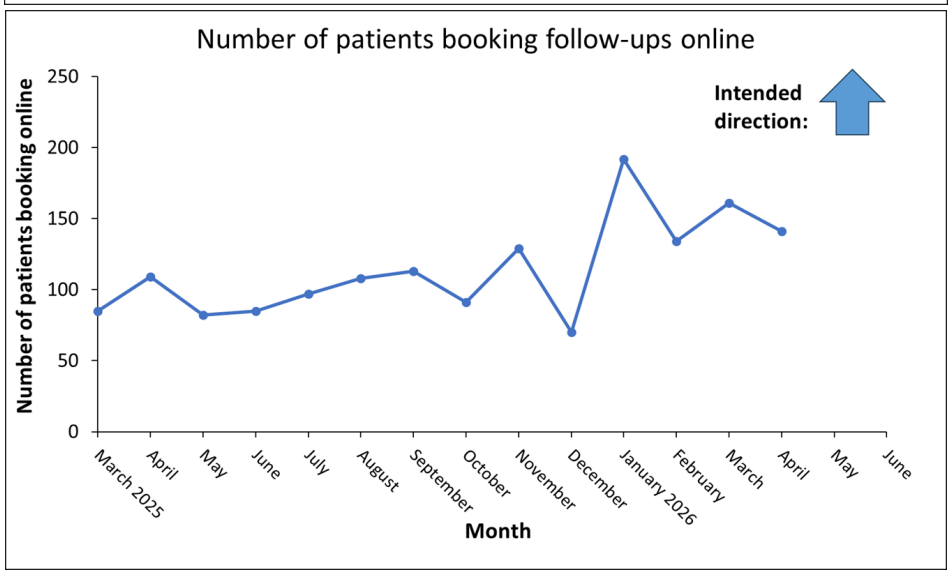
In a community ophthalmology clinic in Victoria, the following change ideas were implemented to build a sustainable booking system for patients requiring long-term care.

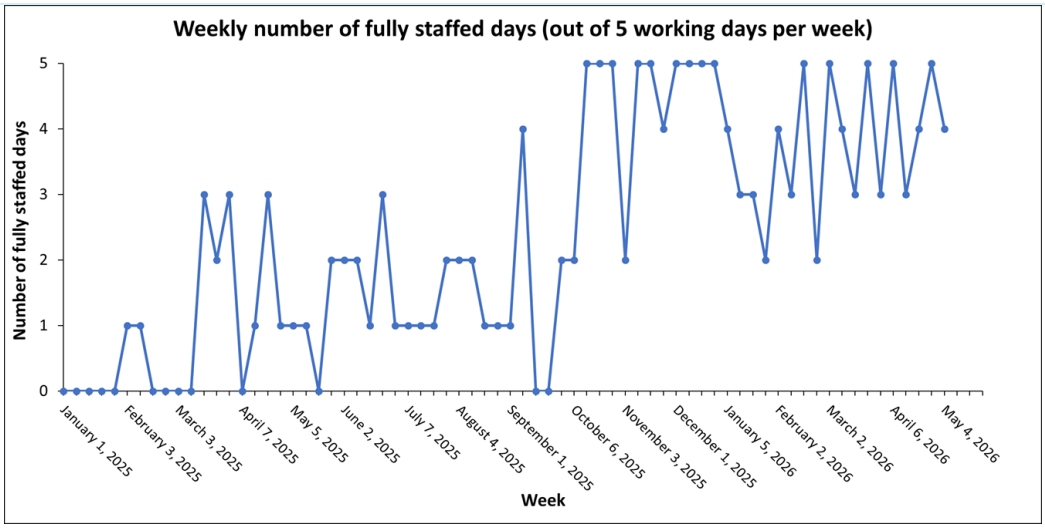
- **PDSA 1: Patient tracking**
    - May 2025 task board for lost-to-follow-up patients
- **PDSA 2: Staffing and engagement**
    - May 2025 weekly morning huddles introduced
    - June 2025 external consultant staff interviews
    - June 2025 equal distribution of phone call workload
    - June 2025 huddle frequency increased to daily
- **PDSA 3: Booking system optimization (hybrid online and phone)**
    - August 2025 phone calls for all patients 2-weeks after online booking emails
    - October 2025 online testing slots tripled per time slot
    - November 2025 booking window extended to two months ahead
- **PDSA 4: Automated reminders**
    - January 2026 one-week automated email reminder for patients to book
    - February 2026 day-before text reminders for booked appointments

Data Analysis:









Lessons Learned:

- Technology alone cannot drive change
    - Patient and staff engagement remained the rate-limiting step
    - While digital tools (online booking, automated reminders) added capacity, the system's effectiveness remained contingent on patients using the platform and staffing resources to follow-up with phone calls
- Scalability and sustainability
    - Growth in patient population outpaced manual outreach
    - As the patient population grew, so did the volume of reminder calls
- Online booking invitations generated unintended phone call volume
    - When patients received email invitations to book online, a significant proportion responded by phoning the clinic instead. This increased inbound call volume rather than reducing it, creating a bottleneck that affected access for patients with urgent eye care needs who could not get through to staff

Next Steps:

- Booking at point of care with patient-led rescheduling
    - Book follow-up technician appointment at front desk after consult (not subject to changes in physician availability)
    - Online booking system or email if patient needs to reschedule
    - Phone lines left open for emergencies, not appointment logistics
- Remote staff to increase phone line capacity
- Reduced physician oversight to build staff-led sustainability

OPTIMIZING PATIENT REFERRALS TO THE PREOPERATIVE RESILIENCE & OPTIMIZATION PROGRAMME (PROP)

Physician Lead:	Dr. Karen Johnsson & Dr. Sonja Mathes
Location:	Victoria, RebalanceMD
Specialty:	Family Practice; Orthopaedics

Background:

RebalanceMD, a multidisciplinary musculoskeletal care clinic in Victoria, BC, offers an eight-week Presurgical Resilience and Optimization Program called "PROP" for patients undergoing major orthopaedic surgery. PROP was developed with medical evidence to support the use of mindfulness meditation and CBT skills to help patients improve their mental health, resilience, presurgical activity, nutrition, social support, sleep and pain management, leading to improved surgical outcomes. This virtual program has been offered since 2020 as an MSP covered Group Medical Visit on Zoom. Patient satisfaction and experience measures have been extremely high, with over 96% of patients reporting that they would recommend the course to others and that they feel better prepared for surgery.

Problem:

Ideally, patients complete the PROP prior to their surgical date. Prior to the inception of this project, as many as 36% of PROP participants did not have time to complete the program prior to their surgical date. Additionally, we have had patients that were unable to even begin this preoperative program before their surgical date. Surgical wait times are on average 51 weeks (about 11 and a half months). PROP runs as consecutive 8-week cohorts. Most patients can participate in the next available cohort as there is rarely a wait list. We know that there is a delay from when the patient is placed on a waitlist for surgery and when they are referred to or start the PROP program.

Patient Engagement:

- Will use patient partners from our PROP groups to poll and get feedback about proposed changes.
- We will poll group participants about how they heard about PROP, how they were referred, and the value for them of the intake consultation before PROP.

Aim of Project:

By June 2026, 95% of PROP patients will complete PROP 4-6 weeks before their surgical date. Our project will include Vancouver Island Joint Replacement patients and PROP will be organized via RebalanceMD.

Measures:

Outcome Measure

- Percentage of patient per cohort that have completed PROP prior to their surgical date.

Process Measure(s)

- PROP Referral Volume; PROP Cohorts offered
- Wait time between Surgical Waitlist entry and PROP referral
- Patient Survey – How patients find out about/are getting referred to PROP
- PROP website hits

Balancing Measure(s)

- Number of patient referrals
- Number of patients per cohort
- If interest and enrollment in PROP increases, we will have maximized our current capacity to enroll patients. We are working on increasing capacity, sustainability and spread through:
    - Recruiting and discussing training with new facilitators
    - Updating our Manual and Slides
- Recording the educational content and Meditations exercises to make it available online

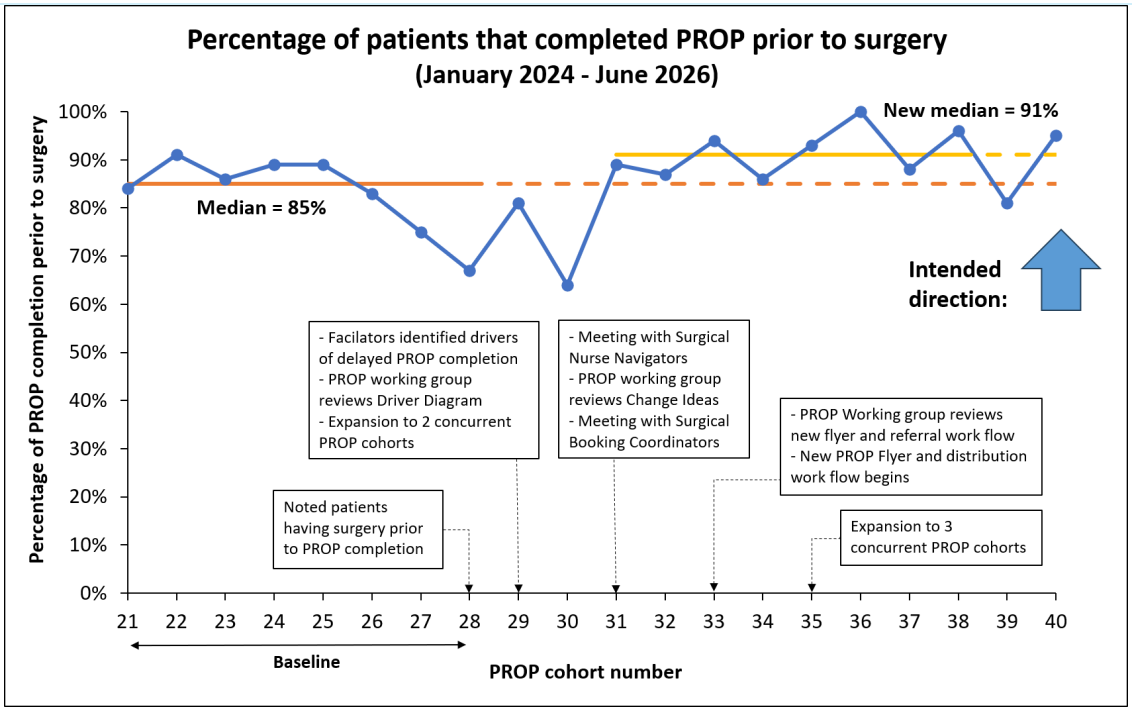
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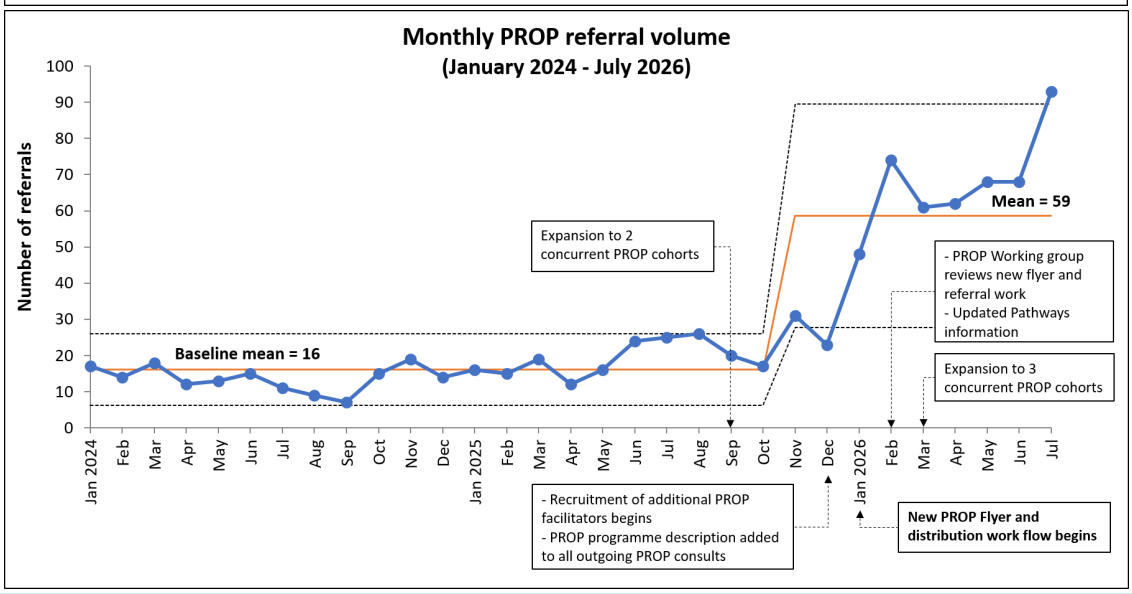
- Meetings with clinical administration team; surgical nurse navigators to discuss problem and develop change ideas
- Adapt patient facing materials with multipronged approach to emphasize the importance of early referral PROP:
    - Updated Flyer with changed language – Infographic style – handed out in print and placed online
    - Patient Flyer placed in prominent position in surgical package
    - Video about PROP emphasizing early referral – NEW
    - Flyer and Video to be placed on REbalanceMD.com

Data Analysis:

Data was manually extracted for retrospective cohorts to establish baseline data, and reporting processes were put in place to yield monthly reporting tools to facilitate program maintenance.

Change ideas led to a trend of more patients completing PROP before surgery with a new median of 91%. Balancing measures including a profound increase in volume of referrals to the PROP, increasing by over 200%.





Lessons Learned:

- Extracting and analysing the data proved to be far more labour intensive that we anticipated. Running filters, automating the extraction likely took more time than a manual extraction would have, especially with multiple meetings required to do this.
- Improving patient facing materials to emphasize early referral increased awareness overall leading to a dramatic increase in referral volume
- Primary Outcome measure should be selected as something that we have greater control over – e.g. we can't control when a patient has surgery; but we can control how quickly they are referred to the program

Next Steps:

- Trial patient self-selection and registration for PROP without a prior physician consult
- Recruitment and training of further facilitators

REDUCING TIME TO COMPLETION OF NON-URGENT REFERRALS

Physician Lead:	Dr. John Kim
Location:	University of Victoria (UVic) Student Wellness Centre
Specialty:	Family Medicine

Background:

Navigating post-secondary education introduces academic, social, and independence challenges that can heavily impact student health and well-being. This transition period coincides with high rates of illness; notably, 75% of Canadian post-secondary students struggle with mental health, where 70% state these challenges actively impair their grades. The impact results in decline in functional capacity, prolonged distress, and academic setbacks. Because most students have limited prior healthcare exposure, navigating our complex healthcare system while sick can be overwhelming. When barriers delay care, students suffer from symptoms, heightened anxiety, and a diminished ability to complete their studies. To prevent these poor health outcomes and to support recovery, healthcare providers and institutions must seek to reduce barriers and support access to care.

Problem:

The University of Victoria's Student Wellness Centre (SWC) consolidated Health, Counselling, and Multifaith Services to reduce barriers and support approximately 22,000 students. Between September 2024 to August 2025, Health Services managed 3,000 visits, with some visits requiring referrals to other services. While urgent referrals are processed within the same day, Non-Urgent Referrals (NUR) can face backlogs, sometimes reaching greater than 4 weeks as of November 2025. These delays compromise student care by stalling access to other services and thereby affecting student functional capacity and performance.

Aim of Project:

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

Measures:

Outcome Measure

- Days to complete Non-Urgent Referrals after the visit date

Process Measure(s)

- Time in minutes to complete 15-minute and 30-minute visits
- Time in minutes to complete the visit note

Balancing Measure(s)

- Clock-out of work time
- Practitioner self-report of happiness score out of 5
- Student survey of 1 question asking if they felt supported by their practitioner during the visit

Action Taken:

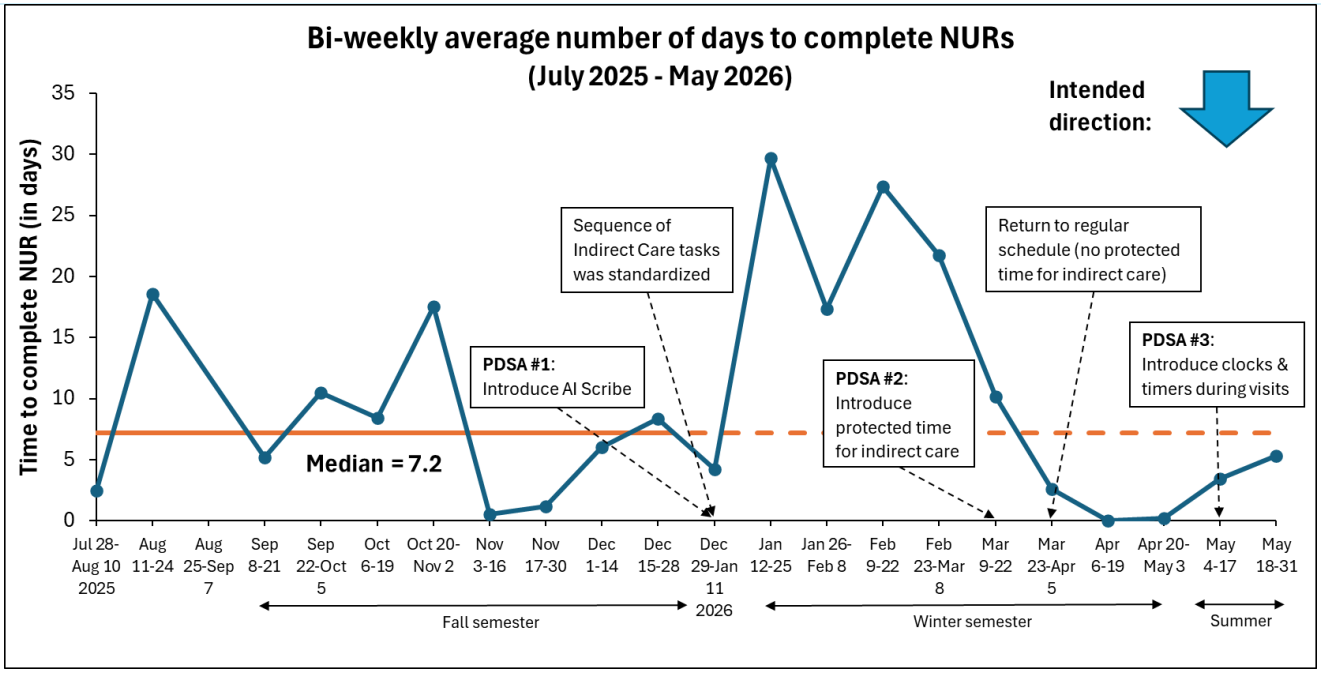
Dr. John Kim's practice conducted PDSA cycles at the UVic Student Wellness Center.

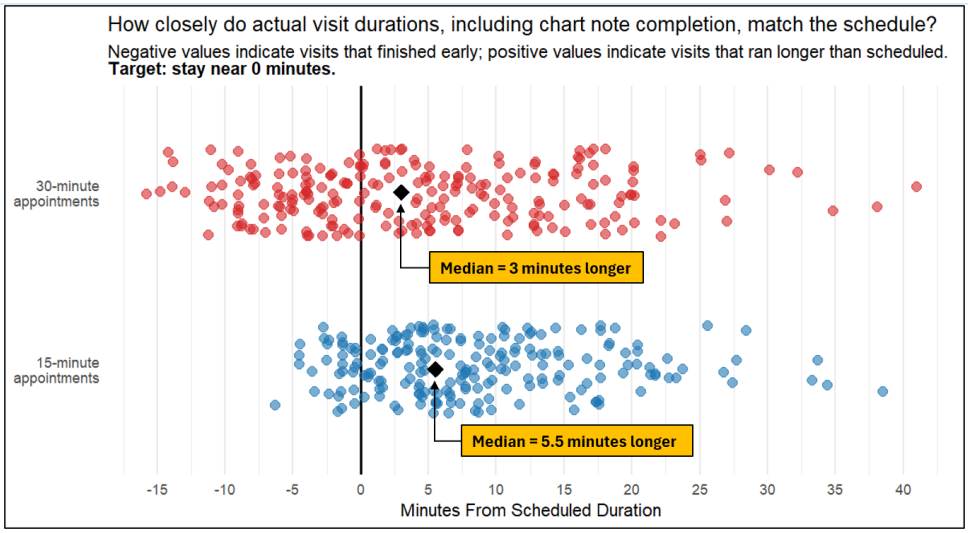
- **PDSA #1 (Dec 2025 – March 2026):** Integrated Heidi AI Scribe to the office visit if student consented. The note generated by Heidi AI Scribe was reviewed before saving the note into the EMR. Heidi AI Scribe was adopted into practice.
- **PDSA #2 (March 2026 – May 2026)**: Episodic conversion of walk-in type of visits were converted to protected indirect care time to complete tasks, including referrals. The hope is to adapt this PDSA cycle to the next iteration of clinic schedule modifications in September 2026.
- **PDSA #3 (May 2026):** Deploy physical and virtual clocks and timers to support in-visit time management. This has been abandoned due to inconsistent use.

Data Analysis:

The Outcome Measure (number of days to complete NURs) was aggregated to Bi-weekly Averages. Heidi AI Scribe alone did not achieve the Aim Statement. Increasing indirect time in an episodic manner helped meet the Aim Statement.

A second chart displays that Actual Visit Durations are often longer that the Scheduled Visit Duration.





Lessons Learned:

1. Heidi AI scribe alone was insufficient to meet the Aim Statement. Therefore, other processes, other than reducing time to write chart notes, are contributing to the timeliness of NUR.
2. The most influential change idea in this PQI project was adding more protected time for indirect care. However, there is the unwanted consequence that available visit appointments were removed which results in a new barrier for students.
3. This project highlights how integrated and connected the system of providing care can be. Each visit encounter is unique and varied and reveals the dynamic nature of providing care within a rigid system.
4. This project also invites the question of one's capacity, and perhaps I am at capacity, or even beyond capacity. It also highlights the concept that capacity is unique to each practitioner. But we have a rigid system that may be limiting the ability to honor the diversity of capacity between practitioners.
5. The balance measure of inviting students to anonymously provide feedback about how supported they felt during the visit felt extremely vulnerable to myself as their clinician, however, this balancing measure is of utmost importance. The students appreciated the opportunity to provide feedback, which highlights their appetite to provide feedback but the lack of opportunity to do so. Working through being vulnerable as a clinician, as well as an organization, may be a valuable exercise.
6. This process of sustaining, or even increasing, capacity while improving efficiency requires a multi-pronged approach, both at the individual level, as well as the organizational level, where a concerted team approach with clear-minded leadership may lead to an organized, effective, and sustained change.
7. The chart revealing that Actual Visit Duration is often longer than Scheduled Visit Duration is a chart that invites further investigation, which may lead to potential change ideas.

Next Steps:

1. Share my experience with UVic staff
2. Discuss with my Director potential schedule changes

REDUCING DELAYS AND IMPROVING SAFETY FOR OLDER ADULTS IN TRIAGE HOLD

Physician Lead:	Dr. Stephanie Niles and Rebecca McGregor (RN)
Location:	Nanaimo Regional District Hospital
Specialty:	Emergency Medicine

Background:

Triage Hold is a designated area in the emergency department (ED) where patients wait after triage while awaiting an assessment space or inpatient bed. For older adults (≥65 years), prolonged stays in this environment can lead to delayed assessment, treatment, and decisions regarding admission, discharge, or transfer, increasing exposure to preventable harm. Evidence demonstrates that extended ED length of stay is associated with higher rates of delirium, functional decline, falls, medication-related adverse events, longer hospital admissions, and increased morbidity and mortality among older adults. The Canadian Triage and Acuity Scale (CTAS) establishes national benchmarks for timely physician assessment and ongoing nursing reassessment according to patient acuity; however, achieving these standards for patients held in non-treatment spaces remains a recognized challenge across British Columbia. Since January 2026, two *Serious Harm* Patient Safety Learning System (PSLS) events involving older adults in Triage Hold have occurred at Nanaimo Regional General Hospital (NRGH). Local staff have also identified concerns regarding patient safety and care quality in this setting, underscoring the need to improve care processes for this vulnerable population.

Problem:

At NRGH, 28% of patients arrive via ground ambulance, with the frail elderly (≥65 years) accounting for 60% of this population. Approximately 50% of these patients are admitted to hospital and wait more than 33 hours for an inpatient bed, spending part of their ED stay in Triage Hold. These patients frequently experience delays in assessment, reassessment, treatment, and decisions regarding admission, discharge or transfer. These delays contribute to safety risks and have been associated with serious patient harm events, highlighting a gap between current and desired care for a vulnerable patient population.

Patient Engagement:

A patient partner reviewed the project and provided input on the Pre-Hospital Functional Screener Form (PDSA #2), a tool completed by patients and families. Their feedback on the form's wording informed revisions to improve patient-centered language and usability. They also provided valuable insights into additional supports that could improve the patient experience, including nutritional offerings, pocket talkers, fidget toys, blankets and signage.

Overall, this project received positive feedback and was felt to bring welcomed change to the care of older adults in the ED.

Aim of Project:

By June 2026, reduce the average time from triage to a 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 NRGH ED.

Measures:

Outcome Measure(s)

- Primary Outcome: Time from triage to disposition
- Secondary Outcome: Hospital related harms (Patient Safety Learning System (PSLS) reported events)

Process Measure(s)

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

Balancing Measure(s)

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

Action Taken:

Through staff feedback, patient partner engagement, and review of care processes, opportunities were identified to improve assessment, monitoring, and disposition planning for older adults in Triage Hold. Three interventions were tested using Plan-Do-Study-Act (PDSA) cycles and subsequently adopted.

- **PDSA #1: Additional LPN in Triage Hold Area *(Adopt)***
    - An ED Licensed Practical Nurse (LPN) was assigned to the Triage Hold area to provide more timely assessment, monitoring, and patient care. *Note: Coverage was inconsistent as it was dependent on voluntary shift uptake.*
- **PDSA #2: Pre-Hospital Functional Screener Form *(Adopt)***
    - A pre-hospital functional screening form already used for admitted patients at NRGH was introduced in the ED and refined with input from a patient partner. The tool provided physicians with information about baseline functional status to support clinical decision-making and disposition planning.
- **PDSA #3: EMS Alcove as Assessment Space *(Adopt)***
    - An underutilized Emergency Medical Services (EMS) alcove was repurposed as a dedicated assessment space for Triage Hold patients, improving access to physician assessment, physical examination, and care planning.

Data Analysis:

- The primary outcome measure, average time from triage to disposition for patients aged 65 years and older in Triage Hold, remained unchanged. The average was **6.25 hours post-intervention, compared to 6.24 hours at baseline**, and no sustained evidence of special cause variation was observed (Figure 1).
- Average time to physician assessment remained relatively stable throughout the project (**1.53 hours baseline vs. 1.58 hours post-intervention**) (Figure 2).

- Comparison with a similar population of older adults cared for outside Triage Hold revealed a shorter average time to disposition (**6 hours**) compared with Triage Hold (**6.25 hours**) (Figure 3).
- No Level 4 or 5 PSLS events involving older adults in Triage Hold were reported following implementation of the interventions.

Figure 1.

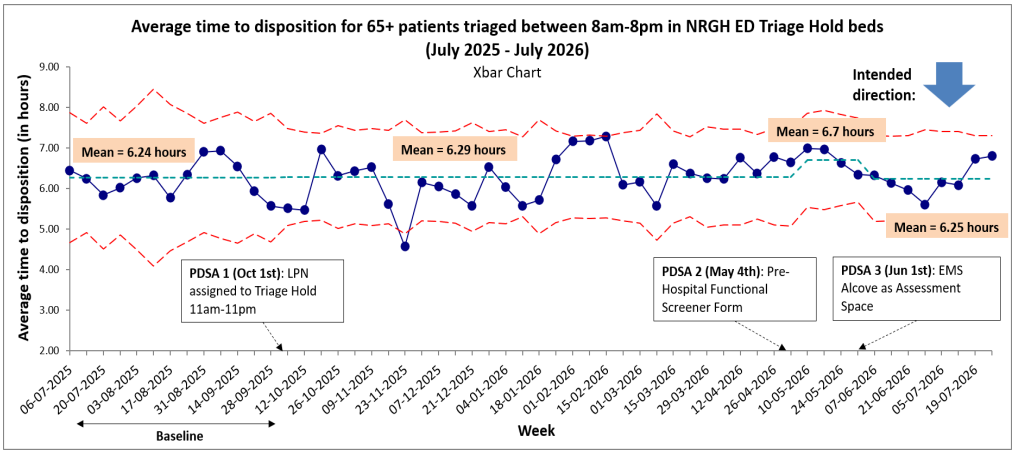


Figure 2.

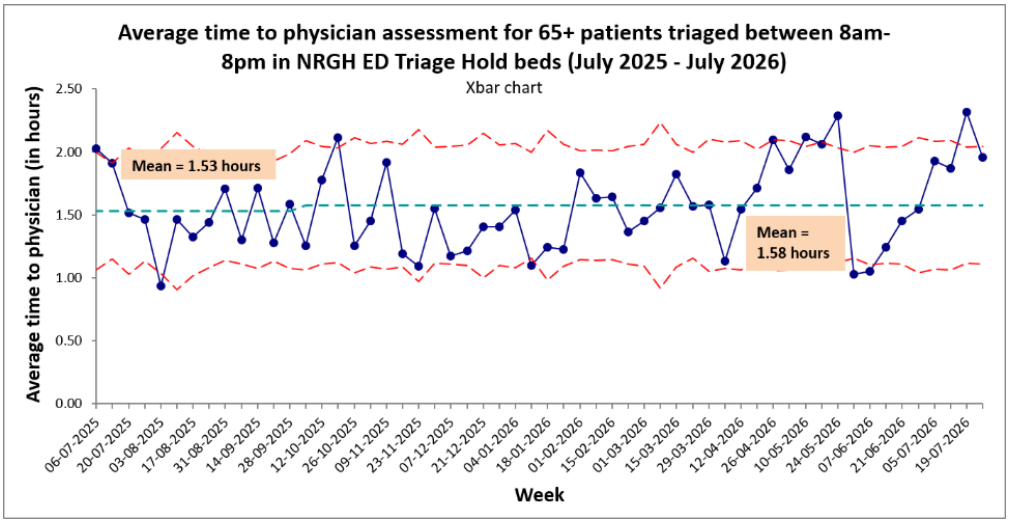
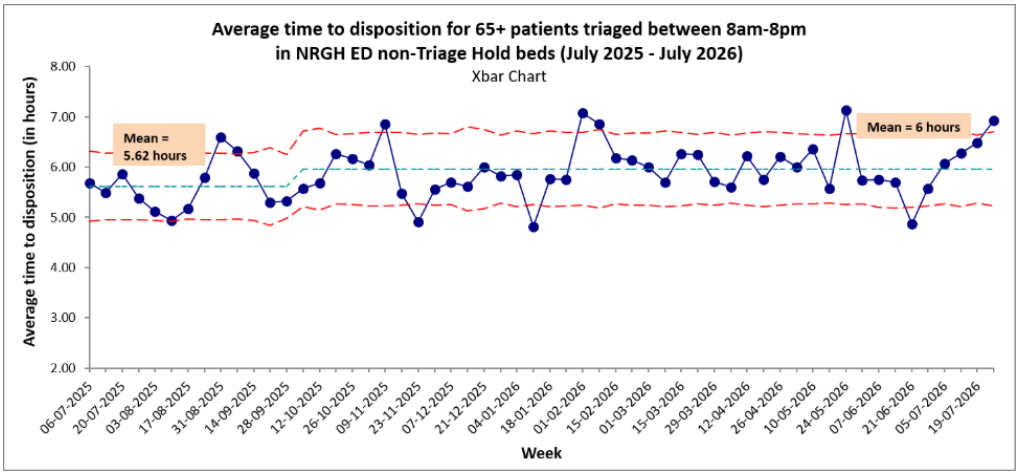


Figure 3.



Lessons Learned:

- **Dedicated Nursing Presence May Improve Safety:** Although the addition of an LPN to Triage Hold did not reduce time to disposition, no Level 4 or 5 PSLS events occurred following implementation. While causation cannot be established, this finding suggests that dedicated nursing presence may contribute to safer patient care and improved monitoring of vulnerable older adults.
- **Time to Physician Assessment Does Not Appear to be the Primary Driver of Delay:** Average time to physician assessment remained approximately 1.5 hours throughout the project and was considerably shorter than overall time to disposition. This suggests that factors occurring after initial physician assessment may contribute more significantly to prolonged ED stays.
- **Physical Environment May Influence Flow:** The approximately one-hour difference in disposition time between older adults in Triage Hold and comparable patients cared for elsewhere in the ED suggests that the care environment may influence patient flow and access to assessment, monitoring, and care planning. The use of the EMS alcove may support more comprehensive assessments, patient flow and timely collection of samples.
- **Functional Assessment Supports Best Practice:** The Pre-Hospital Functional Screener Form did not reduce time to disposition during the project period. However, it supports a standard of care that was not previously being met.
- **Frontline Engagement Enables Implementation:** Strong engagement from frontline staff, physicians, and a patient partner facilitated implementation of the interventions despite ongoing operational pressures. Staff participation and feedback were essential to testing and refining change ideas.
- **Project Limitations:** Inconsistent LPN coverage due to voluntary shift uptake may have limited the impact of the intervention. In addition, the relatively short observation period and low frequency of serious harm events limited the ability to determine the effect of interventions on patient safety outcomes.

Next Steps:

- Expand use of the EMS assessment alcove and monitor its impact on patient flow.
- Work with physician and operational leaders to streamline admission processes following a decision to admit, addressing delays that occur after initial physician assessment.

IMPROVING ACCESS TO COMMUNITY-BASED SKIN BIOPSY

Physician Lead:	Dr. Jill Stone
Location:	Plastic Surgery
Specialty:	Nanaimo

Background:

Patients who have a clinically suspicious skin lesion require biopsy prior to plastic surgery referral for definitive treatment. However, 12.7% of the provincial population does not have access to a family doctor or NP who could biopsy a suspicious skin lesion. Clinics may not have a proceduralist clinician willing or able to perform skin biopsies due to lack of supplies, office space, time, or experience. Delay to diagnoses and/or definitive treatment of skin cancers leads to worsening disease burden, locally advanced skin cancers, and more challenging reconstruction (Seretis 2021).

Within the local plastic surgery group, office biopsy has also not been routine; unbiopsied referrals have often been declined or biopsies performed in hospital minor surgery if necessary. This creates avoidable delays and uses hospital capacity for a procedure that can generally be completed safely in an appropriately equipped office. Establishing a reliable office-based pathway could improve access, shorten time to diagnosis, and preserve hospital resources for definitive surgery.

Problem:

- Currently, biopsies of *undiagnosed* skin lesions referred to our office have been performed in minor surgery at NRGH, utilizing limited resources. Other plastic surgery offices continue to routinely decline referrals without biopsy.
- Non-directive interviews with the Nanaimo Plastic Surgery group reveal reasons to include "my office is not set up for it", "I just don't have time", "we have more than enough work already", and "the cost is too much to do in office."
- As such, these referrals have historically been declined placing administrative burden on referring physicians/NP, increasing demands on dermatology wait list in the community, and increasing patient wait time to diagnosis (self-reported by patients).
- Unbiopsied skin-lesion referrals have historically been declined by local plastic surgery offices or booked into NRGH minor surgery, where they use limited hospital time and resources. Semi-structured dialogue interviews with colleague plastic surgeons identified practical barriers: offices were not equipped for biopsy, clinicians lacked time, the work was poorly reimbursed relative to its cost, and established referral practices
    - *"my office is not set up for it"*
    - *"I just don't have time"*
    - *"we have more than enough work already"*
    - *"the cost is too much to do in office."*
- Patients were therefore redirected to their primary care clinician or the community dermatology wait-list, adding administrative work for referrers and delaying diagnosis.

A consistent office-based biopsy pathway was needed to accept appropriate unbiopsied referrals without displacing other clinical care.

Patient Engagement:

Patients were engaged throughout implementation during clinical encounters and follow up. Our office explained prior to the appointments the rationale behind their biopsy clinic appointment and what the appointment could achieve – namely, a soft tissue diagnosis. The patient feedback confirmed that uncertainty while waiting for diagnosis was particularly difficult and having a dedicated convenient pathway was highly valued. Comments included: "Waiting was the hardest part," "I felt like I didn't know what the next steps were after I heard that it could be cancer," and "I'd much rather come to your office than go to the hospital." This feedback reinforced the project's focus on timely access, clear next steps, and a patient-centred office setting. This project involved a patient partner who reviewed patient material to ensure the information was appropriate and useful.



Aim of Project:

By April 2026, increase the number of skin biopsies performed in Dr. Jill Stone's plastic surgery clinic in Nanaimo, by 100%.

Measures:

Outcome Measure

- Number of in office biopsies (#)

Process Measure(s)

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

Balancing Measure(s)

- Breast reduction encounters per month - a surrogate for ensuring other types of consults are not reducing as skin cancer encounters increase
- Workplace satisfaction (self and employees) (Burnout Scale Numbers and Job Satisfaction survey as total score comparison, tri-annually)

Action Taken:

PDSA #1: Open Access to Unbiopsied Lesions – update pathways, fax to referring offices, notify other plastic surgeons. No change.

PDSA #2: Build a Centralized Referral Pathway- Create a centralized referral form for unbiopsied lesions, pathway triage, new fax number – monthly meetings with GP-Derm partner, define accepted referrals.

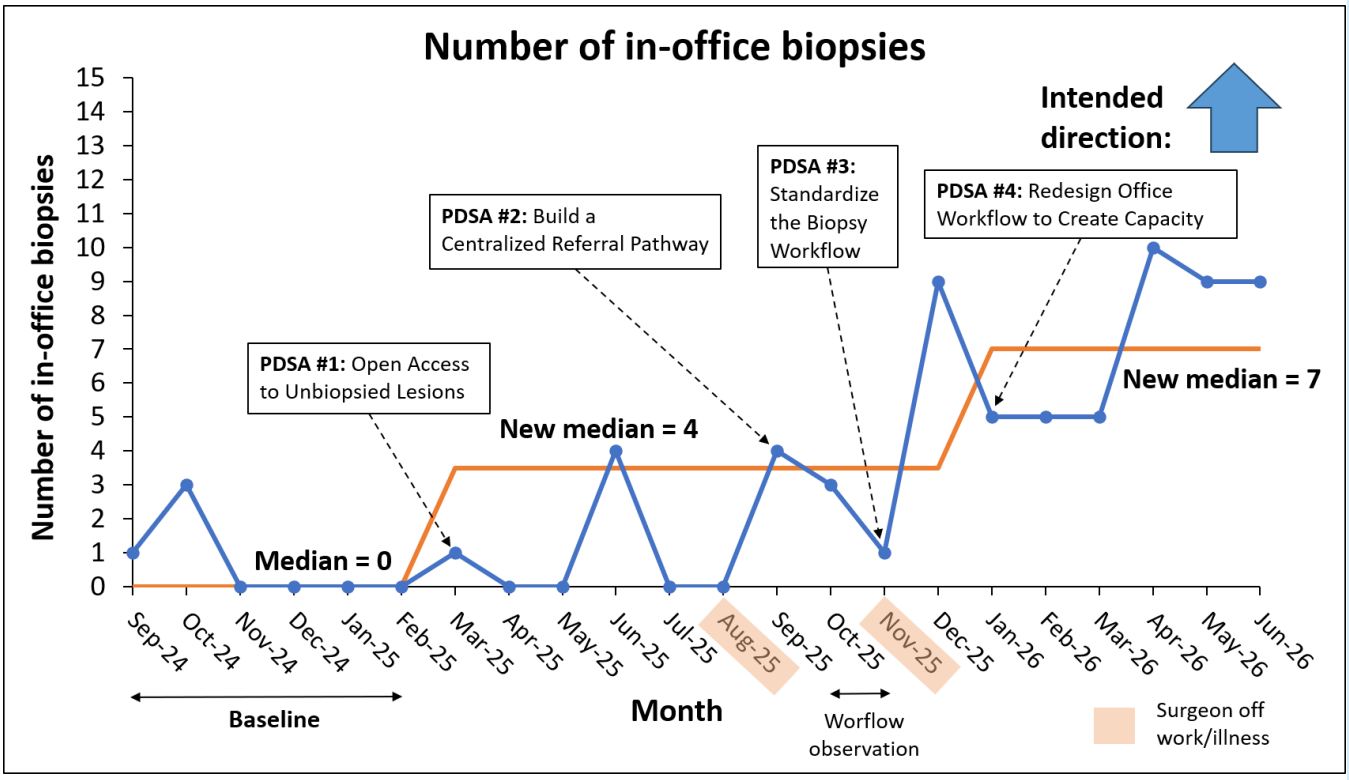
PDSA #3: Standardize the Biopsy Workflow - Streamline biopsy set-up, simplify biopsy tray (cost reduction), biopsy template paperwork and aftercare.

PDSA #4: Redesign Office Workflow to Create Capacity – Practice audit October 1-November 1. Refer to Appendix 1. Dedicated Biopsy-Clinic Time, introduction of Ocean e-forms, patient teletracker, room numbers, encourage front desk team to engage in multi-tasking, appointment reminders for patients to arrive early if they cannot complete their forms online.

Data Analysis:

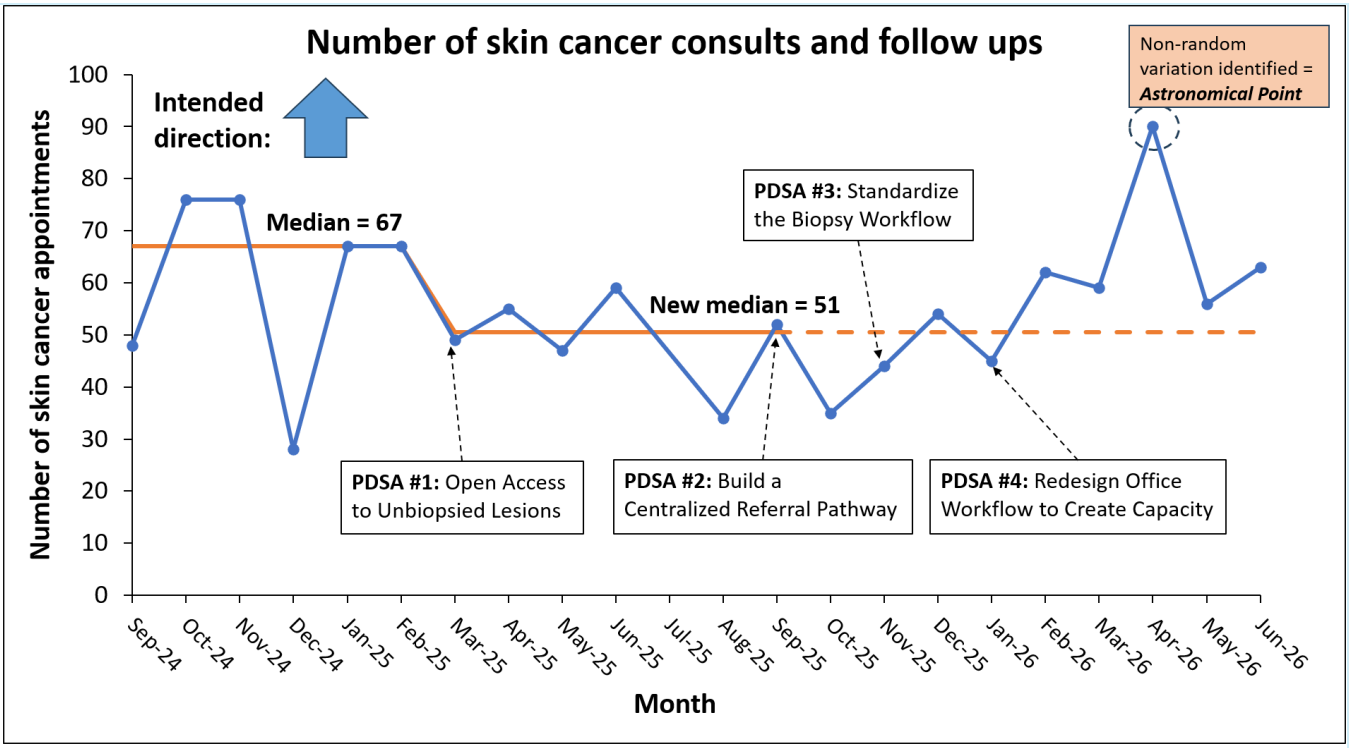
Outcome Measure

Number of biopsies performed in office showed improvement, increasing to 4 per month following PDSA#1, and then to 7 per month following PDSA #4, despite temporary reductions during surgeon absences in Aug and Nov 2025.

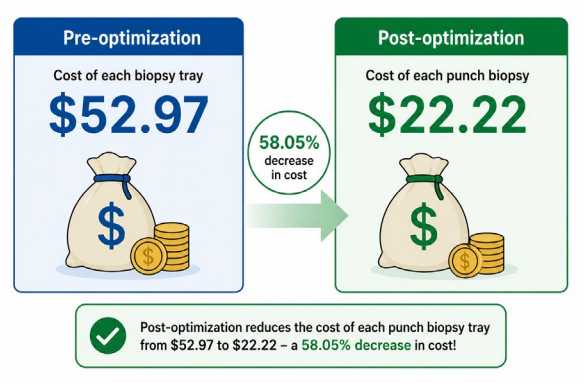


Process Measure

Median number of non-procedural skin cancer visits initially fell after PDSA#1 by 23.9% but later improved following workflow redesign. This shift likely represents clinician time dedicated to developing PDSA cycles #2 and #3, alongside an increased volume of procedural appointments within constrained capacity.

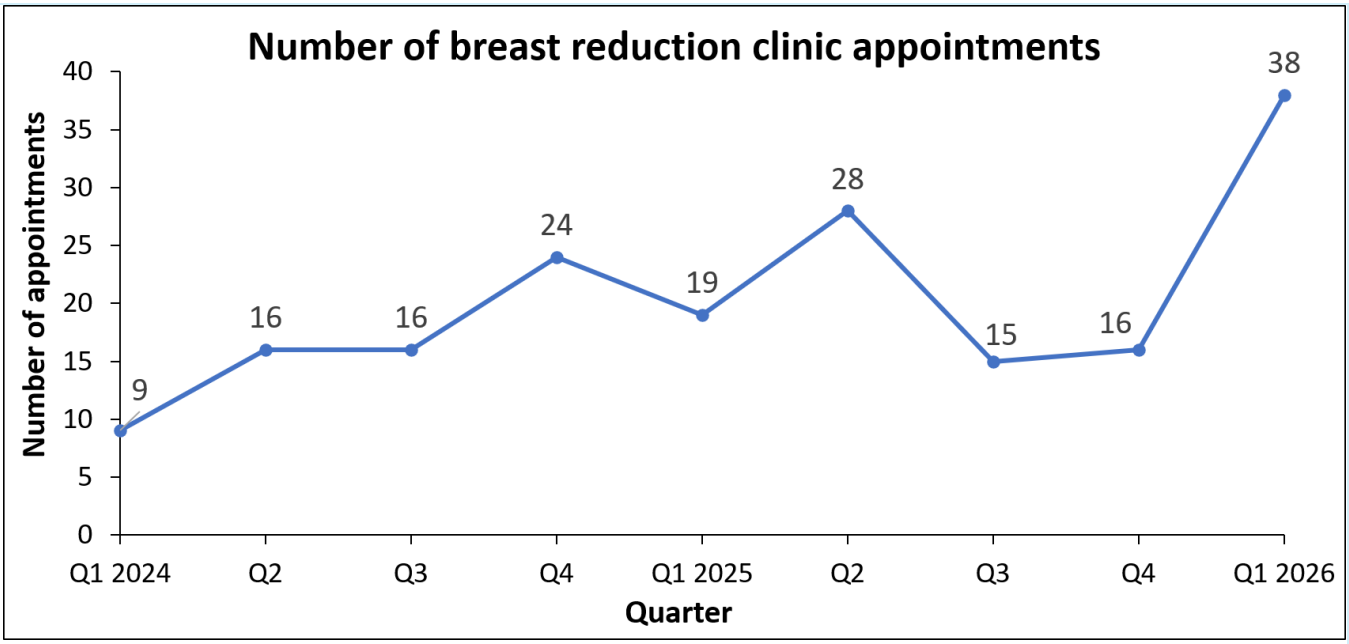


Optimization of procedure tray decreased costs by 58% per biopsy which reduces the cost barrier to in-office biopsy days.



Balancing Measures

Monthly breast reduction appointments increased comparing 2025 to 2026 and quarterly. We anticipated lower capacity but office efficiency changes from PDSA #4 translated to improved breast reduction consult capacity.



A 10-point job satisfaction survey using a scale from 1 (very unsatisfied) to 10 (very satisfied) was used tri-annually for office staff. Temporary 1 point reduction (8/10 to 7/10) mid project due to increasing administrative burden during project.

Lessons Learned:

- **Lesson #1:** Office costs remain a barrier to performing in office biopsies
- **Lesson #2:** In office efficiency can be improved to see more patients without working more
- **Lesson #3**: Doing 'the right thing for patients' can come at a higher cost, both personally and at hospital setting
- **Lesson #4:** Total cost savings including supplies at hospital are difficult to determine
- **Lesson #5:** Idea spread is achievable. A newly joined locum physician completed >40 biopsies in August 2026, helping us maintain our commitment to community healthcare

Next Steps:

- **Next Step #1:** Plastic surgery group education and spread – optimization of other offices so that we can accept unbiopsied lesions in other practices.
- **Next Step #2:** Ensure < 30 day wait for biopsy appointment, recruitment of other physicians if necessary
- **Next Step #3:** Use lessons learned from PQI to improve practice efficiency – goal: reduce breast reduction waitlist next

PERIOPERATIVE ANXIETY IN CHILDREN

Physician Lead:	Dr. Alison Tedder
Location:	Victoria, Saanich Peninsula Hospital
Specialty:	Anaesthesiology

Background:

- Paediatric dental surgery is often the first encounter with the medical system and operating room.
- The first experience should preferably be a good one that does not leave a patient with a degree of anxiety for a future encounter.
- There are unintended and costly outcomes associated with a poor experience due to perioperative anxiety for children which presents 40-75% of the time.
- Health care induced distress 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.
- Continued anxiety with health encounters related to dental needs could result from any unpredictable traumatic encounters.

Problem:

Locally, our team did not have a method of identifying anxiety nor of treating it in a consistent and patient-specific way. We were seeing a problem of some children coming for dental surgery that were incredibly anxious and under prepared for the procedures that they were about to undergo. In addition, many children may have in fact been anxious, but their distress was not obvious.

In all, perioperative anxiety has had multiple effects on our local team:

- Increased distress for attending staff
- Delayed discharge due to delirium on PACU
- Poor patient experience and outcomes

Patient Engagement:

Patient was referred as a partner via another clinician on the team. For this project, the patient partner was asked to share her overall experience as the mother of three-year-old who had come in for dental surgery. The mother reported an overall good experience but noted that the waiting area could provide a more child friendly environment. Her experience also highlighted the importance of varied approaches of identification and treatment across different ages of children.

Aim of Project:

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

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

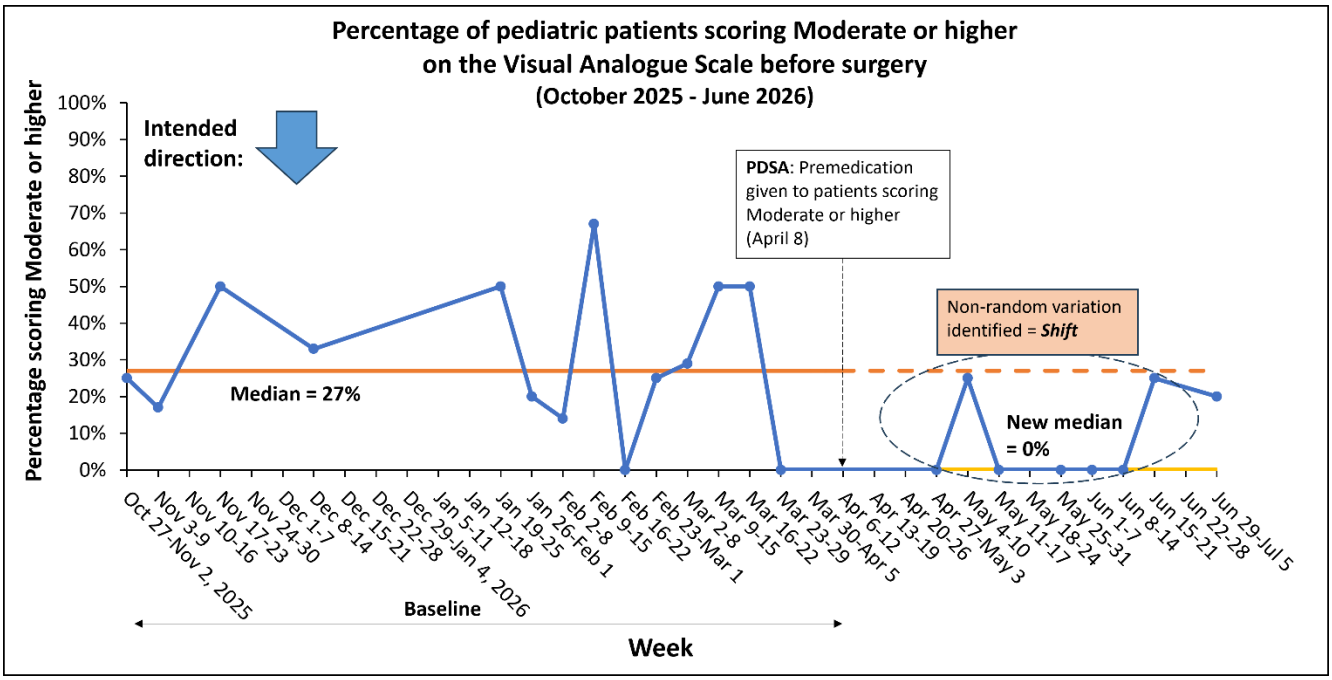
Balancing Measure

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

Action Taken:

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

Data Analysis:



Lessons Learned:

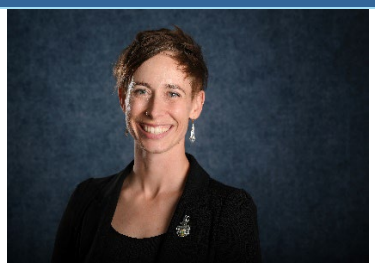
- **Lesson #1**: Screening revealed surprising discrepancies between clinician perceived patient-anxiety versus a child's self-reported anxiety
- **Lesson #2**: Using a validated screening tool limited staff's ability to modify and created some initial negative feedback
- **Lesson #3**: Emergence of 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 PDSA's 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 offered 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

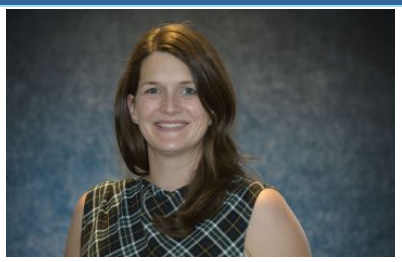
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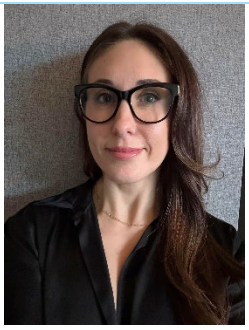
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