David Lawson and David Handley succeeded in pulling off the first amalgamation of services between Fraser Health and Vancouver Coastal Health

The Collaborators

>>AN AVOIDABLE DEATH: Lessons learned
>>POST-SURGICAL INFECTIONS: The battle rages
>>DISPATCHES FROM QATAR: FH alumni’s tales
>>GRASSROOTS GREENING: Starter projects
>>PASSIONS: Our chairman tangos

David Lawson (l), Fraser Health; David Handley, Vancouver Coastal Health
Looking at this month’s cover, you may just see a photo of two genial-looking gentlemen in suits who have amalgamated some of the support services of Fraser Health and Vancouver Coastal Health. Simple. But when I look at that photo I see their collaboration for the monumental achievement it is – how, I wonder, have they managed to pull that off when photographer Jerald Walliser and I couldn’t manage to get them in one place at one time until just days before this magazine went to press, despite making dates starting back in November.

These are busy guys, as you might imagine given the task they were faced with. But once we nabbed them for the photo, they graciously gave us the time we needed and their humor made them a pleasure to work with. Allie MacRae’s article The Collaborators begins on page 20.

An article beginning on page 6, Dying to be Heard, should give you more proof that Fraser Health is committed to being open and transparent as it can with you, its valued employees, physicians and volunteers. This is the story of a situation Fraser Health regrets, but which has inspired it to learn from errors and change practice around senior care. Human beings make mistakes; it’s by facing them and making changes that we improve.

Lots of other interesting tales in this issue but I particularly want to direct your attention to a new section on page 31: Passions. Our chairman Gordon Barefoot and his wife Cheryl launch the feature with a demonstration of their passion for ballroom dancing. Suggestions for future subjects are welcome.

And finally, our first piece of paid advertising appears on the back cover: a conceptually brilliant ad from BC Transplant. If you are reading the online edition of InFocus, you can click on the web address to register your interest in organ donation.

As always, I hope you enjoy the issue. Please let me know what you think and what stories you would like told.

Bonnie Irving
Editor
‘I wanted to let you know how much I enjoyed the Fall 2008 InFocus. I read every page and was entertained, informed, excited and inspired. Good work.’

Linda Nelson
Clinical Nurse Educator
Surrey Memorial Hospital Surgical Program

Nurses need more kudos
I read the article Fighting the Odds in InFocus today. It was a very intense story with a great outcome – thanks to the doctors and NURSES who attended this employee/patient.

However, after I finished the article, I was angry for the rest of the day. It was great how the doctors did all the work (getting the praise) and not a mention of the registered nurses, who worked just as hard. They may not have had their hands on her heart, but the doctors didn’t do this by themselves – which is how that article perceives it. The only mention of a nurse was under the headline – “How a fast-acting team of doctors and nurses saved the life on one of their own.” I am a Registered Nurse. I don’t work in Emergency, but I feel slighted and disrespected by our own organization that touts its values as Respect, Caring and Trust.

This attitude and storytelling is commonplace in the medical emergency shows on TV. The Fraser Health Authority has a ways to go to acknowledge, value and respect the work of Registered Nurses. Registered Nurses are professionals and it would be nice if at least the employer treated us as such.

Helene Greenaway
RN
Ridge Meadows Hospital
Stroke care ramps up

In Canada, stroke is the leading cause of major disability, the second leading cause of dementia, and the fourth leading cause of death.

These sobering statistics are driving a collaborative effort between The Ministry of Health Services, the regional health authorities and the Heart and Stroke Foundation to develop a comprehensive stroke prevention, treatment and management strategy across the province.

Fraser Health will open three Transient Ischemic Attack (TIA) Clinics in early 2009 at Royal Columbian, Surrey Memorial and Abbotsford Regional Hospitals. The service will be accessible to all emergency departments, family physicians and patients across Fraser Health.

Approximately one in 20 patients diagnosed with a TIA in an emergency department will have a full-blown stroke during the following 48 hours. Providing them rapid access to preventative treatment may help reduce the chance of stroke, and save lives. More info: www.fraserhealth.ca/HealthTopics/Stroke Care JENNIFER GROVER

Joint replacements to almost double

Burnaby Hospital’s expanded Hip and Knee Centre is almost doubling its annual joint replacement surgeries to more than 700 from 385 by the end of March 2009.

To support the increase, the hospital has re-commissioned an operating theatre and added eight new beds. A new orthopaedic surgeon, Dr. Tim Kostamo, and other area surgeons are performing additional surgeries. Referrals are being accepted from anywhere in Fraser Health directly to the next available surgeon or a surgeon of choice.

The hospital is also developing a leading-edge Optimization Clinic to help patients prepare for surgery, improve their outcomes and decrease the risk of post-operative complications.

More info: www.fraserhealth.ca/Services/HospitalServices or contact: Cindy Laukkanen Tel: 604.897.8390 Cindy.Laukkanen@fraserhealth.ca JENNIFER GROVER

Fall prevention work earns kudos

The Falls and Injury Prevention Coalition recently awarded Burnaby Hospital an Award of Excellence for its proactive approach to preventing falls and injury in older adults in acute care settings. Starting in 2005, Fraser Health’s Fall and Injury Prevention Acute Care Clinical Working Group piloted an initiative at Burnaby Hospital to prevent falls and in-hospital hip fractures among senior patients.

Hospital physiotherapists, led by Dena Gartner, spearheaded the successful application of hip protectors for patients at risk for a hip fracture. The number of hip fractures dropped by 80 per cent at Burnaby Hospital, which now boasts the lowest rate of in-hospital hip fractures in Canada among other hospitals of comparable size.

The Fraser Health Falls Prevention Mobile Clinic team also accepted an Award of Excellence in Clinical Practice: Community Prevention. The clinic has traveled all over the Fraser Valley to demonstrate fall prevention to various communities. Fabio Feldman accepted the award for Tenacity and Perseverance for his work as Fraser Health Manager of Fall and Injury Prevention in Older Adults. JENNIFER GROVER

Safety incident reporting improves

Since implementing the Patient Safety & Learning System (PSLS) in five hospitals – Delta, Burnaby, Peach Arch, Eagle Ridge and Langley – these hospitals have seen a significant increase in the reporting of safety events, near misses and hazards.

PSLS provides a tool to report events without placing blame on individuals whose actions are well-intentioned but resulted in unintentional harm. To date, more than 650 reports have been entered into the PSLS system. Surrey Memorial is the next hospital to implement this system commencing. EILEEN McALEAR

Nominations for Above & Beyond

Recognize and celebrate the outstanding achievements of Fraser Health employees, physicians and volunteers who go ‘above and beyond’ the call of duty.

Nominate an individual or a team for behaviours, actions and achievements under the following categories: Service delivery excellence; Creativity and innovation; Positive work environment; Evidence-based practice; Collaborative partnerships; and Living our values.
The deadline is March 31, 2009 and nomination forms are online at www.fraserhealth.ca. **EILEEN McALEAR**

**How would you rate your health and workplace conditions?**

As part of Fraser Health’s Great Workplaces strategy, we want healthy employees working in healthy workplaces. Workplace Health will be emailing a survey to employees in February to find out how you perceive the health of your workplace as well as the state of your own health.

The information is confidential and anonymous and will highlight workplace areas that need improvement from a physical and psychosocial perspective. For the first time, Workplace Health will have a snapshot of the health of Fraser Health employees and can then plan programs and services that would best support and encourage employees in making healthy lifestyle choices and managing chronic health conditions. **EILEEN EILEEN McALEAR**

**Discharge follow-up a lifeline to post-op ortho patients**

A simple phone call to patients following joint replacement surgery at Langley Memorial is making patients happier and healthier while optimizing health care resources.

Since January of this year, Clinical Nurse Educator Kim Smith and Patient Care Coordinator Leane Sutton have been calling patients at home within 24 to 48 hours of hip or knee surgery to assess their recovery and address any concerns. Complications following orthopedic surgery tend to occur in the first two weeks, most of which are now typically spent at home.

A survey of 75 patients contacted between January 28 and April 8, 2008 revealed post-operative issues such as swelling, constipation, infection, nausea, vomiting and pain. In the past, these symptoms would have sent some patients to the hospital or doctor because they didn’t understand what was happening, explained Sharon Parent, Quality Improvement and Patient Safety Consultant for Langley Health Services.

Now, the nurses listen to patients’ concerns and recommend the appropriate therapeutic approach, which can include education, medication or tests. Sometimes a visit to a doctor or hospital is warranted. **KATHLEEN BUTLER**
Dying to be Heard

Senior Esther Winckler died an avoidable death. This is the story of how Fraser Health learned from that regrettable incident. By Joanne Severn

Verizon Wireless launched its now-iconic TV commercials in January 2002. The Coroner’s Judgment of Inquiry into the tragic death of Esther Winckler at Chilliwack General Hospital was released four months later. My imagination conjures up this vision of Esther ‘up there’, two years after she died, whispering to everyone involved – “Can you hear me now?”

Sadly, Esther’s voice wasn’t heard until long after she was dead. The Coroner’s report was a disturbing rebuke of the treatment she received in an acute care hospital.

“It was devastating to read what actually happened,” Esther’s daughter Catherine recounts. “We were there. We knew that things had gone terribly wrong, but the details were quite shocking.”

In hospital for hip replacement surgery, the 77-year-old was given a general anaesthetic, contraindicated by her history. Post-op congestive heart failure went unidentified and therefore untreated. She fell twice, suffering head injuries that were not thoroughly investigated. The fact that she had not had a bowel movement in over a week was uncharted. The delirium brought on by hypoxia was “managed” by restraining her in a wheelchair with a leather belt strapped around her painfully distended belly. Ultimately, the cause of death was “ischemia and infarction of the bowel and brain as a result of prolonged oxygen de-saturation and hypotension.” Essentially, she died from a host of complications that culminated in a lack of oxygen and blood flow.

No one listened to Esther, or to her family. They had tried desperately to explain that, before her arrival at hospital, Esther was lucid, active, independent, and planning to take a cruise; that this now “difficult to manage” patient was an extremely sick woman presenting in an exceptionally uncharacteristic way.
Esther Winckler’s daughter, Catherine, (r) and Fraser Health’s Marcia Carr worked to turn Esther’s tragic death into her legacy.
Treating old people isn’t sexy
Meeting the unique health care needs of older adults is a growing problem. There are more than four million Canadians over the age of 65 and fewer than 200 geriatricians. Marcia Carr, one of less than 100 Clinical Nurse Specialists (CNSs) in geriatrics in Canada, says that “treating old people just isn’t sexy.” The forthright Carr, who works at Burnaby Hospital, continues: “In truth, a geriatrician faces the most challenging and multifaceted cases in all of medicine, but our society undervalues seniors, and that gets reflected everywhere, including health care.”

There are more than 186,000 people over the age of 65 in the Fraser Health region. According to Carr, “Close to 80 per cent of our hospital beds are occupied with older adults, and we have fewer than 125 beds on units that specialize in acute geriatrics.” Carr fumes when she hears derogatory terms like ‘bed-blockers’ to describe these long-stay seniors. “These are patients. They don’t want to be here. They are here because they need our acute care,” says Carr emphatically. “If more people knew the big differences between how older adults present when they are sick, which includes the interplay of normal aging, pathology and chronic disease, older adults would get the timely, appropriate care interventions that they need, and a lot more of them would be able to get well sooner and go home.”

From lawsuit to legacy
Following Esther’s then-unexplained death, shock and confusion soon led to anger. Catherine’s father and brother wanted to sue, but legal action couldn’t be initiated until after the Coroner’s inquest.

“It wasn’t that we thought these doctors and nurses were bad people,” Catherine says, “but they had done a bad job, and that wasn’t something we were willing to stop talking about.” Catherine put up a website and launched a personal campaign to tell others their story. She wrote letters and made phone calls – hundreds of them – but got little in response. It wasn’t until the Coroner’s report was released that they finally understood what had happened. It was an explanation so distressing that the family as a whole quickly agreed that their focus needed to be on saving others from a similar nightmare.

“Mom was a teacher,” Catherine explains, “and we realized that we had to get beyond revenge to something she would be proud to have as her legacy. It made more sense to us to push for an open and honest dialogue that could serve to educate, than a monetary settlement that would likely come with a gag order.”

Front page news opens doors
At 6 a.m. on May 22, 2002, Catherine was surprised to hear the door bell ringing so early in the morning. Her visitor handed her a cup of coffee and a copy of The Vancouver Sun, and said, “I think your life is about to change.” The newspaper’s front page headline read Woman’s illness, injuries went untreated: coroner. She died after routine hip surgery. There were three full pages of coverage. Catherine’s efforts had paid off. Esther’s story was now front page news.

With the story now very much in the public eye and the family’s rejection of any legal action, things started to happen. The Registered Nurses Association of BC was the first to call, saying that they’d assigned CNSs Pamela Ottem and Phyllis Hunt to investigate. Cathy Weir, Fraser Health’s Director of Quality Improvement and Patient Safety, also said she would take action, and asked Marcia Carr to work with Hunt at Chilliwack Hospital. After two years, the proverbial ball was now not just rolling – some rather tenacious “pit bulls” had sunk their teeth into it and would carry that ball further.

Carr reminisces about those early days. “The stories that participants shared with us were incredibly distressing. At one workshop a nurse walked in the door crying! She was so burnt out. She felt totally helpless about what was happening at her facility. When we heard her story, we went straight to the Chief Nursing Officer, and that worrisome practice was changed – the system changed because she spoke to us. So we were not only educating, but were a conduit to the powers that be to implement systemic change.

“We ended every workshop really encouraging the participants to use us in whatever way we could possibly be of help, and they did. I got a phone call one day from a remote community with only three care staff. They had an older man who’d been catheterized for some time and that was creating problems, but they didn’t know where to start, what to do first. I coached them over the phone. I explained a procedure; they tried it and called me back. Then I told them the next step. We just kept calling back and forth, and you know what? It
worked! After two weeks, that patient was catheter-free.”

Three years after they’d begun, the Collaborative had an epiphany of sorts. As they taught, they also learned, and came to realize that most older adults enter the system through Emergency. They rubbed their collaborative magic lamp, and out came a GENI.

The Geriatric Emergency Nursing Initiative (GENI)

Marcia Carr attended a U.S. training session for Emergency department nurses and heard language she found abhorrent. Terms like GOMER – get out of my ER – referring to patients that presented with seemingly minor complaints. Questions like, ‘Why do they come in to Emerg when they have a DNR?’ In a room of 200, Marcia was silent, but in her head she screamed – ‘Because they’re not dead yet!’ Most disturbing was that she’d heard this many times before.

Back home, Carr rounded up an ED Clinical Nurse Educator, a critical care CNS, a pharmacist and a geriatrician. They developed a new training session and held a one-day pilot with 16 participants. “Very seasoned Emerg nurses started crying,” says Carr. “They could all think of cases they had just seen in the days prior and felt horrible about their lack of knowledge.”

“The tone is set in Emerg,” Carr explains. “The triage nurse’s initial assessment is crucial, and you can’t assess older adults the same way you do younger ones. A complaint of indigestion and shortness of breath in a senior could actually mean that they are infarcting right there as you’re talking to them!”

With additional funding from the Nursing Directorate, the Geriatric Emergency Nursing Initiative (GENI) workshop was expanded to two days and offered to nurses and anyone else eager to learn more. A GENI e-learning module was also developed so staff can quickly learn the high alerts needed when caring for an acutely ill older adult.

A binder of prompt cards was also produced on what Carr refers to as the Geriatric Giants, including delirium, dementia, depression, continence, falls, constipation, dysphagia, pain, unsettled behaviour, skin and wound care, and suicide prevention. The binder contains a tab for each, with assessment and diagnostic flow charts leading to best practice-based treatment plans.

Integration begins to evolve from initiatives

The ACGNN workshops continued for six years, the GENI program for three, with some 2,000 nurses in BC attending. When their funding for travel ended in March 2008, Carr looked to technology to continue the education process. The GENI workshop is available on video, along with a myriad of other resources, on the ACGNN website (www.acgnn.ca) operated by the CNSs on their own time.

The provincial Telehealth program also offers training, facilitated by Carr and others who present on specific older adult topics.

“Getting back to Esther,” Carr continues, “her story is a part of everything we’ve done, and will continue to do. The Winckler family’s commitment to forego legal action and their right to privacy was an incredible gift to us all. Instead of talking about a contrived and fictional case study, we talk about Esther – a real person that we failed to help. That really gets people’s attention, because we’ve all encountered someone like Esther, we’re all going to be someone like Esther, and that makes it personal.”

Both Fraser Health and the ACGNN CNSs continue to tell the bittersweet tale in staff orientations, national conference presentations, and a variety of other learning opportunities. In November 2007, Fraser Health implemented a disclosure policy directing health care providers to promptly inform patients and their families when mistakes have been made. In March 2008 a “least restraint” policy was adopted along with clinical practice guidelines and assessment tools. The ACGNN CNS Collaborative is partnering with Fraser Health’s Geriatric Clinical Services Planning and Delivery team to produce more e-learning modules on the geriatric giants. In August 2008, Abbotsford Regional Hospital, the first hospital built in BC specifically designed to be elder-friendly, opened its doors. Other programs to improve access and quality of care for seniors are underway.

Make Esther’s credo your own

The silver lining of that heavenly cloud where I envision Esther now perched, continues to grow. In addition to the activity at the ACGNN and Fraser Health, Catherine still gets phone calls and emails from around the globe. Nursing students write to tell her that the website she set up, www.Esther’sVoice.com, is required reading in their studies, and families call to ask for advice and to thank her for sharing her personal experience.

Is there more to be done? Yes, and it’s up to you to do it. One of Esther’s credos was that one should never leave to others what they themselves have the power to accomplish. You have the power. Watch the workshop or do the e-learning online, take part in the video conference training, attend presentations, ask questions, and most importantly, listen.
In Search of the Tipping Point

How do you change long-practised behaviours of health care professionals who believe their actions are always in the best interests of their patients? You convince three leaders from Surrey Memorial Hospital to share with the rest of Fraser Health what they have learned about reducing post-surgical infections. By Bonnie Irving

Surrey Memorial Hospital’s Chief of Surgery, Dr. Peter Doris, stands on the shoulders of giants, if you’ll forgive the cliché. This passionate crusader for the prevention of surgical site infections in Fraser Health ORs has taken up the fight that Dr. Joseph Lister began in the mid-19th century. Lister was the first surgeon to figure out that Louis Pasteur’s ground-breaking work connecting rotting and fermentation to micro-organisms could explain what happened post-surgery to many (most) patients: the surgery was successful – but the patient died of infection.

From today’s perspective, the methods of the first modern surgeons, who practiced on the battlefields in the Napoleonic Wars of the early 1800s, or the ‘barber surgeons’ of the same period, appear barbaric. Lister’s decision to douse hands and instruments with carbolic acid before and after surgery was a turning point in the prevention of infection.

But despite ongoing discoveries, surgical infection today remains a stubborn enemy.
Dr. Peter Doris, Chief of Surgery, Surrey Memorial Hospital, is the visionary behind the efforts to spread the lessons learned at SMH.

“When people figure out for themselves that they have to change, they will.”
According to U.S. stats, out of 30 million operations a year, infection affects two percent or 600,000 patients and results in increased readmission rates, longer lengths of stay and increased costs. Surgeons are often unaware of infection in their own patients, says Doris, because it may only show up post-discharge. Family doctors see the results, but the surgeon remains oblivious. Without personal knowledge of the issue, asking surgeons to make changes to processes they think have served them and their patients well can be difficult.

Nevertheless, that is the challenge Doris, Lorraine Gillespie, SMH Director of Surgical/Ambulatory Programs, and Martha Grypma, Managing Consultant, Quality Improvement & Patient Safety, took upon themselves, backed by a team of interprofessionals, including CNEs and Infection Control Practitioners. Now having successfully piloted process changes at SMH over the last five years, they are sharing the lessons learned with all Fraser Health OR, PACU and surgical nurses, as well as surgeons and administrators.

Lorraine Gillespie chuckles as she looks back at how easy she thought some of the process changes would be to make at SMH. Motivated by some regrettable incidents that made headlines five years ago, the hospital had been working hard to create a safety culture and to look at how they could do a better job of preventing surgical site infections (SSIs).

Through Martha Grypma, Gillespie got wind of a successful U.S. campaign being launched as the Safer Healthcare Now! Collaborative in Canada that was evidence-based and promised to reduce SSIs by a whopping 40 percent. Both were excited by the possibilities of introducing the program to SMH, so Lorraine signed up a Surrey team in the western node of the Collaborative. “It was from that collaborative,” says Grypma, “that we set up our own Fraser Health Surgical Safety Collaborative using similar aims to those of the Safer Healthcare Now! Collaborative.”

Meanwhile, Peter Doris was following the findings that originated in the Veterans Affairs (VA) hospitals in the U.S., which had come under fire for dreadful infection rates in the 1980s. Forced by Congress to get its act together, the VA system contracted non-clinicians to collect objective patient data 30 days post-operatively. And what a shock surgeons got when they discovered that one-third of their patients were getting infections (the definition of which had been standardized) after discharge. Unfortunately, those results were replicated in civilian hospitals.

Thus began a massive transformation of systems and processes in the OR and the introduction of a systematic measurement of outcomes. In the VA hospitals, the program became known as the National Surgical Quality Improvement Program (NSQIP). It was based on establishing a measurement system, defining variations in performance, identifying best performers and best practices, and distributing the information to others. It was soon adopted by the American College of Surgeons (which includes Canada). Says Doris: “For the first time, the introduction of a measurement system was shown to change behaviour and to influence mortality and morbidity.”

So while Doris enrolled SMH in NSQIP (RCH is the only other Canadian hospital registered and Burnaby will soon follow), Gillespie approached him about the Safer Healthcare Now! bundle of evidence-based elements that promised to drastically reduce infections. Says Gillespie: “If it was already proven that these processes could reduce infections, why wouldn’t you implement them?” For her, Doris and Grypma, it
was a no-brainer. After all, these were not brand-new ideas. How hard could it be to sell processes that had been proven to succeed and that many had already heard about?

The Surgical Site Infection bundle they proposed to pilot with the surgeons and nurses at SMH comprised three main elements:

- Antibiotics administered 15 to 60 minutes before the first incision and discontinued within 24 hours
- Hair removed using clippers not razors, which cause microscopic breakage in the skin, potentially leading to infection
- Patient warmed up before, during and after surgery to reduce post-operative hypothermia

How easy was it to enlist support for the pilot? Responses from physicians varied: from why would we want to change?, to we are not having a problem, to not enough research is being done to warrant a change, to we are not having a problem, to we are not having a problem, to we are not having a problem, to we are not having a problem, to we are not having a problem, to we are not having a problem, to we are not having a problem, to we are not having a problem.

From anaesthesiologists: why would we want to change?, to we are not having a problem, to sounds reasonable, will do.

From OR nurses... well, you get the point. In short, change is difficult to initiate.

But no one shut the door entirely, and Doris, “the visionary”, as Gillespie calls him, and Grypma and Gillespie, “the doers,” in her words, pressed on. In the end, most ended up willingly trying to adapt to the changes.

Leaning towards tipping

So how's the spread to other sites going? Royal Columbian Hospital, another large site, for example?

Miriam Stewart, Director Acute Programs and specifically the Operating Rooms and Critical Care areas, says RCH decided to start by focusing on the antibiotic timing part of the bundle. "We had no clipper problems," she says "so we figured we would go where we had the biggest opportunity for improvement. And that was antibiotic timing." The hospital chose to focus initially on General Surgery, specifically colon resection patients who were already the focus of another change initiative and were being audited.

And the accomplishments to date? Laminated guidelines are now posted in each OR and in PACU and the general surgery pathway has been updated to include clear antibiotic timing. "Having it written as part of the pathway is an important step," says Stewart.

Going forward, RCH will continue to audit charts and educate surgeons and OR nurses. Says Stewart: "We have some strong champions for this initiative, surgeons such as Dr. Rory Van Heest and Dr. Peter Blair, and anesthetists like Dr. Rob Sharpe. At RCH, we all know it's the right thing to do. So we'll just keep at it."
It was a daunting task, but it was one they embraced with enthusiasm. Says Gillespie: “You need a lot of energy to put into this. This needs to be something you believe in.”

So they borrowed learnings from the western node of the Safer Healthcare Now! Collaborative and built on some of the successes of the Arthroscopic Hip and Knee Collaborative to create their own unique Surgical Safety Collaborative. The plan: bring teams together from across Fraser Health; utilize a show-and-tell format over a series of four sessions; and focus on the SSI bundle but reintroduce Site Marking (initialing the correct leg for amputation, for example) and the Surgical Pause (taking a deep breath before every surgery to verify the right patient, the right procedure and the right site or side), both of which has been previously implemented in all surgical areas under Ridge Meadows OR nurse Bonnie McLeod’s leadership. Each acute site would choose what it wanted to take on first and in what service.

The Quality team of Martha Grypma and Lori Hughes worked with other faculty members and developed the agenda for the learning sessions, the measurement plan and how to help teams in the action periods. The basic principles to achieve the goal: start small; test often; work with those who will work with you; use the power of data over time; and develop a communication plan. Each acute site put a team together and most attended the first session in October 2007, which included a presentation from the Safer Healthcare Now! Collaborative. Meanwhile, Doris, the Collaborative’s physician champion, held an evening session for about 15 surgeons and anesthetists interested in the work. No doubt the Principle of Diminishing Astonishment got some play that night.

To guide the change process, the Collaborative leaders needed to thoroughly understand the medical culture, which has clinical autonomy at its core. They also had to understand how to get buy-in from the surgeons by knowing what makes them tick and understanding that they are not schooled in systems thinking, improvement models, communication techniques and the like. Much of that ‘bureaucratic stuff’ they regard with mistrust. Doris kept stressing the importance of the team in accomplishing what the Collaborative chose as its common theme: quality and safety for our patients.

In between sessions, the Collaborative held monthly teleconferences with the site teams to share learnings and challenges, asked for monthly reports of tests and outcomes, and gathered monthly data.

The final session was held in October 2008 and the improvements since the launch were unveiled. Among them:
- Antibiotic Timing: increased from 44% compliance to 83%
- Antibiotic Discontinuation: 35% to 56%
- Site Marking/The Pause: 90-100% doing regularly
- Clipped Hair Removal: 90% to 96%
- Normothermic in PACU: 53% to 62%

Challenges remain but phase two will focus on each team sustaining and spreading the improvements until they are hard-wired into the system.

Doris will continue to preach the benefits of the NSQIP program, and other initiatives, such as Team Resource Management, a system of pre-surgery checks borrowed from the airline industry. It will be trialed at SMH and potentially introduced to all of Fraser Health.

Says Peter Doris: “The very fact that you are engaged in monitoring, influences results...We all want to do better.”

And if you really want a demonstration of Doris’s passion for the cause, just stop him in the hall and ask him to tell you about NSQIP, which was a bit beyond the scope of this article. Make sure you have plenty of time for his answer.
You’ve probably seen the organ donation registration cards from BC Transplant at your doctor’s offices or at insurance agencies. Maybe you even picked one up. But is it still sitting in your ‘to do’ pile to be filled out when you get around to it?

As someone who received a life-saving kidney and pancreas transplant 5½ years ago, Surrey resident Sally McKinstry knows first-hand that waiting is not a luxury for hundreds of British Columbians.

A type-one diabetic since age 16, McKinstry experienced a number of complications over the decades, including kidney failure. Eventually, with her health rapidly failing, a transplant became her only option for survival. She went through neurological, psychological and blood testing to confirm her suitability and was placed on the transplant waiting list. She then waited 2½ years with her life in the balance, not knowing if she would find a compatible donor.

Advocates for organ donation want you to think about how you could save others... if the worst should happen to you.

BY MEGHAN WOODS AND JENNIFER GROVER
"In the first year, I had what is called a dry run," she explains. "I was compatible with a donor. I was literally sitting on the bed, ready to go, when I got a phone call to say the donor was not compatible after all. I felt like I had been hit by a Mack truck. I went through the gamut of emotions from high to low – from being excited to feeling guilty and upset for the donor family.

"It was discouraging. By the second year, I was getting really ill. My eyesight had deteriorated, my kidney failure was eight years in progress, and I was getting more sick, more often. The dialysis was not working well and I was vomiting every morning. I couldn’t get out of bed. I would not have lasted another year."

Halfway into the second year of waiting, and just six days after another emotional dry run, McKinstry finally received her long-awaited kidney and pancreas transplant.

"I never lost faith. I took very good care of myself, and I believe that’s what made me live long enough to have the transplant."

A double transplant like McKinstry’s is so rare that only two or three such procedures are done every year in the Lower Mainland. Although still technically classified as a diabetic, her pancreas is functioning normally and she no longer has to take insulin treatment. After 31,000 needles – she stopped counting – life without diabetes and its complications is a gift that has made her life easier than she ever imagined. Putting her gratitude into words is a little more difficult.

The donor gave me my life back, she says, holding back emotion. "I went back to school and started a new job. I live a full life with kids, cats and dogs."

In British Columbia, despite overwhelming public support for organ donation and the simple registration process, only 16 per cent of residents have legally registered their decision, one way or another. That figure is even lower in Burnaby, where, as of last April, just 10 per cent of BC citizens had registered.

Dr. Susan Kwan’s initial response to that statistic was emphatic: “As a clinician, I can do something about this!”

Kwan, director of Intensive Care and head of the Department of Medicine at Burnaby Hospital, did take action, becoming the founding force behind ‘Project Give Life’, a multi-layered campaign encouraging organ donation in Burnaby. The project, which was launched last spring at the beginning of National Organ Donor Awareness Week and ran through the summer, represented a unique partnership between the city, community leaders like Kwan, Burnaby Hospital and B.C. Transplant Society.

“There is lots of need for a program like this in Burnaby,” says Kwan, recognizing that the more than 30 minority groups in the city pose an interesting challenge in encouraging donor education. An active member of the Chinese-Canadian community in Burnaby, Kwan emphasizes that it isn’t just about increasing numbers, it’s also about increasing awareness among different ethnic groups and tackling misconceptions and fears about the organ donation process. To help break down these barriers, SUCCESS, one of the largest immigration and social service agencies in BC, partnered in the project, reaching out to new immigrants in their own language, and with cultural sensitivity.
Do it now

It’s easy to register your decision about organ donation on BC’s Organ Donor Registry. (See the outside back cover of Infocus.) BC is the first province in Canada to offer a complete online, legal organ donor consent system that lets residents register quickly and efficiently online as organ donors.

- Register online: www.transplant.bc.ca
  (You need a valid BC Care Card to register online)
- Register by phone: 1.800.663.6189

BC Transplant is an agency of the Provincial Health Services Authority.

In addition, local service providers such as the fire department, police department, libraries and small businesses became involved in the project, promoting organ donation within the community.

Tina Todorovic, an RN in Burnaby Hospital’s Critical Care Unit, has observed an organ recovery operation. “It was done with the utmost respect,” she says. “I am 110 per cent behind this project.”

Because there is less than a one per cent chance of someone being eligible to donate his or her organs for transplant surgery – due to the extreme delicacy and complication of organ recovery – Kwan kept the campaign focus as broad as possible. “If you are a human being, then you are a potential donor!” she says. Her eventual goal is a 100-per-cent registration rate in Burnaby.

The majority of potential donors pass away suddenly – often from a trauma. Asking a grieving family to decide whether to donate the organs of their loved one is uncomfortable for hospital workers. That’s why every individual is encouraged to decide for themselves and register their personal wishes. It can also save the lives of potential organ recipients, who are in a race against the clock. Keeping the body’s organs alive and functioning for a lengthy period of time is difficult and waiting too long may mean missing an opportunity for donation.

Whether or not you want to be a donor, McKinstry stresses the importance of signing a donor card or registering your wishes at BC Transplant’s new online system and discussing them with your loved ones. She says that knowledge of your wishes, either way, makes an organ donation decision easier for families in grief.

“It takes 30 seconds to save someone’s life,” she says. “My donor saved seven lives.”

At any given time in the province of British Columbia, 350 people are waiting for lifesaving organ transplants. They are given pagers and told to wait indefinitely for their second chance at life.

Only three BC hospitals perform transplants – VGH, St. Paul’s and BC Children’s. But all hospitals, including those in Fraser Health, may be involved in referring potential donors to the BC Transplant Society. Since Royal Columbian Hospital is the trauma centre for Fraser Health, it provides the bulk of the organs from this health authority.

Today, Sally McKinstry takes every opportunity to talk passionately about her transplant and the importance of organ donor registration. She paddles with the Gift of Life Dragonboat Team and volunteers for the B.C. Transplant Society.

“I wouldn’t be seeing my grandchildren if I didn’t have a transplant. I am one of the lucky ones. There are kids and adults on the transplant waiting list who die.”

“The heavens have to align for it to happen, but when it is successful, it’s like grabbing people back from death,” says Penny Richardson, Director of Organ Donation and Hospital Development for B.C. Transplant Society.

When you give, you’re building care where it matters most.

RCH is the heart centre for the largest and fastest growing region in the province. More than 1.5 million people from Burnaby to Boston Bar depend on RCH to provide emergency open heart surgery and angioplasty.

When every second counts, so does every dollar.

Visit rchfoundation.com or call 604.520.4438

Today, you can help fund a cardiac retractor and provide lifesaving open heart surgery.

infocus WINTER 09 17
I was sound asleep when the telephone rang in the early morning hours of July 31st. Within minutes, I was wide awake and driving up the King George Highway towards Surrey Memorial Hospital where I am a thoracic surgeon. As with all emergencies, I knew I would need to get there fast.

As I headed towards the hospital, I prepared in my mind the explanation I would give to police if I got pulled over. Knowing that every second mattered, I was ready to quickly accept whatever punishment the officer handed out so that I could get to the hospital as soon as possible. Fortunately, the patrol cars I passed were already preoccupied with other drivers.

I would soon learn that my patient was 31-year-old Manolo Cruz, who had been rushed to Emergency suffering from a life-threatening stab wound to the chest. Cruz had been dropping off a friend at a Skytrain station after a long day of painting when they came across a young woman being assaulted by a man. Cruz, father of two young children, had stepped out of his vehicle and yelled at the man to stop. For that, he was stabbed once directly in the heart. The assailant left, along with the woman Cruz was trying to help.

In the moments after he arrived in Emergency, Cruz was unconscious and in critical condition. His chest cavity was filling with blood.

Emergency physician Dr. Craig Murray was the first to see Cruz. He made a quick decision to call me in while he, the nurses and other members of the team in the ED attempted to stabilize Cruz. Immediately they placed a chest tube into his left chest but it soon stopped draining when it became plugged with clotted blood. He needed immediate surgery.

While I was enroute, the surgical department was preparing the operating room for me while also dealing with a gunshot victim who had been brought in for emergency surgery. The efforts of my colleagues in coordinating all this could not have been executed any better.

By the time I arrived – about 10 minutes after waking up to the sound of my telephone – the patient had already been given about a litre of blood. He would need another litre before the end of the night.

I would rely on Drs. Nigel Findlay-Shirras, Dick Lee, and Lori Fuller as well as a whole team from the OR for help. Operating room nurses Lydia Kendrick, Debbie Fraser and Heather Ballantyne, along with Anaesthetic Assistant Penny Polischuk were all involved as we attempted to save the man’s life.

Normally, as a thoracic surgeon, I would not do open heart surgery – the elective kind anyway. However, we will do emergency trauma surgery that might involve the heart, or the sac and great vessels around the heart. We are trained to perform open heart surgery so as to be comfortable around the heart... particularly for traumas.
Our elective practice takes us close to and onto the heart regularly. For example, in removing lung, which is a huge part of our practice, we divide the vessels right at the heart and from time to time have to remove tumours from the side of the heart. So we are all pretty comfortable working around the heart.

But emergency trauma cases always cause a bit more of an adrenaline rush than elective cases. So when I walked into the Operating Room I was primed for action and totally alert. After opening Cruz’s chest and reaching his heart, I found a one-inch laceration in the top of it and a chest full of blood. In a trauma scenario such as this we would not stop the heart and go onto bypass. Instead we would do the repair while the heart was beating. We are trained to that but are rarely called upon to do so.

As I placed my finger on the hole to stem the loss of blood and allow the OR team and Dr. Lee to continue to stabilize the patient, I noticed a police officer sitting in the corner of the room, as they often do in cases like this. Not that it would have mattered to any of us in our efforts to save this patient, but I asked the officer whether the patient was a ‘good guy’ or ‘a bad guy’. The officer replied that Manolo Cruz was one of the good guys. I felt a renewed wave of determination sweep over the entire team.

Very carefully, I put five sutures – placed with small pieces of surgical felt to prevent the sutures from tearing through fragile muscle tissue – in Cruz’s heart. I had to time each suture with each beat of his heart to avoid tearing the tissue and making the hole even bigger. Once that was complete, I closed his chest. He was stable now, and I knew he would survive. It is in this kind of moment that I relish being a surgeon and a member of the Surrey Memorial Hospital team.

I was later asked by a journalist whether Cruz’s survival was a miracle. While you could consider it a divine act, I prefer to think of it as the health care system working as it should.

From the Emergency Department to the Operating Room, my colleagues made quick and accurate decisions. As a result of the team at Surrey Memorial Hospital, Manolo Cruz is now back at home with his wife and children.

“While you could consider it a divine act, I prefer to think of it as the health care system working as it should.”

Dr. James Bond
Meet the two Davids who have turned the support services of Fraser Health and Vancouver Coastal Health into one operation, saving $30 million in only six months and leaving more of each health authority’s resources destined for direct patient care

BY ALLIE MACRAE

The Collaborators

Vancouver Coastal’s David Handley (l), Fraser Health’s David Lawson (r)
When Fraser Health CEO Dr. Nigel Murray took over the reins of this organization in October 2007, he has said he saw early on that health care in the Lower Mainland operates in silos. “People kept referring to ‘Boundary Road’, and when I first heard of it, I kept asking for its name – ‘The boundary road is called what?’ “ Murray wrote in Infocus. “Apparently this road was considered some sort of border beyond which Fraser Health employees and patients dared not tread… Within my first few weeks I met with Ida Goodreau, my counterpart in Vancouver Coastal Health, to discuss how we could help each other to provide better health care to the population of the Lower Mainland.”

According to Murray, Boundary Road should be invisible and should not set a boundary around planning. In looking at how partnerships could serve the needs of patients in both health authorities, he believed that non-clinical services could benefit from collaboration, which in turn could lead to greater resources being available for direct patient care. It’s that belief that set in motion one of the first major collaborations between Fraser Health and Vancouver Coastal Health (VCH).

In early 2008, faced with ever-escalating operating costs, the senior management teams of Fraser Health and Vancouver Coastal Health met to discuss how they could provide more cost-effective health care by working together in a bold, new way. A logical first target, they thought, might be to integrate the infrastructures of the two organizations. These departments provide much of the support that allows patient care and clinical support departments to run smoothly. The focus was on the portfolios of Fraser Health’s Shared Services and VCH’s Business Initiatives and Support Services – Food Services, Housekeeping, Laundry and Linens, Purchasing, Replenishment and Logistics, and, in Fraser Health, Sterile Processing.

These workers provide the food patients eat and the linens on which they sleep, purchase the supplies and equipment used for patient care, and, in Fraser Health, sterilize the instruments surgeons and nurses use in the ORs. These services are a crucial, but largely unseen, and often unsung, part of patient care.

By integrating the two portfolios (Shared Services), the executive teams believed they could leverage business relationships to obtain lower pricing by combining purchase volumes and working toward standardization of supplies and equipment. By collaborating, the authorities could work together to achieve more than they could by acting alone; economies generated could then be reinvested in direct patient care.

Once the executive teams agreed to amalgamate the support services of both organizations, the implementation of this massive undertaking was entrusted to Fraser Health’s Chief of Shared Services, David Lawson, and VCH’s Executive Director of ValueIN and Support Services, David Handley. Both men took a deep breath and set to work to figure out together how to make the amalgamation seamless – with as little pain to all as possible. As Nigel Murray had told Infocus: “The prospect of change can be unsettling but we must look forward if we want to realize our goals.”
So, how do you amalgamate the Shared Services of two independent health authorities? The two Davids would need to overcome many challenges, including two different computer systems that make combining purchase orders very difficult, different end dates on purchasing contracts, different products and vendors, different policies and procedures, and different staffing structures. This would be uncharted territory with no roadmaps, no signs, no clear paths. To be successful, the Davids would have to create one new organization out of two segments of two larger organizations. Not only would the cultures be different between Fraser’s Shared Services and VCH’s Business Initiatives and Support Services, but each was also part of a larger health authority with its own culture and ways of doing things.

It was a challenge both would greet with optimism – and some trepidation. The two Davids come from very different backgrounds and possess different skill sets. As co-creators of this new organization, their strengths would need to mesh in a way that would ensure a successful amalgamation. Between them, they would need business savvy, a solid understanding of the needs of the clinical system, experience negotiating major deals, a background in human resources and employee relations, and a familiarity with the difficulties change could bring for employees of both organizations.

As it turns out, they would each bring to the table the necessary skills and those they lacked they would seek in their teams.

David Lawson came to health care following extensive private-sector business experience, a background useful in the roles he would later play in Fraser Health. After earning a Commerce degree from McGill University, he became a manager with an audio-visual retail store in Montreal and later the Inventory Control / Distribution Manager for Eastern Canada with Eaton’s. From there he moved to his first position in health care, as the Materiel Manager for the Royal Victoria Hospital, a teaching hospital on the campus of McGill University. In 1991, Lawson was recruited by the Fraser Burrrard Hospital Society in BC.

The transition into health care was a natural one, Lawson says. “Health care is a nice fit for my lifestyle – helping people inspires me and in my position I can help system work better, which in the end translates into helping people.”

After holding the Director of Materiel Management position through the regionalization of the BC health care system in 1996 and 2001, Lawson became the Chief of Shared Services for Fraser Health in 2004. He oversaw the creation of the state-of-the-art warehouse and office facility in Langley and the integration of the Purchasing departments of the three former health regions that now make up Fraser Health. That smaller-scale experience with amalgamation would come in handy in this new assignment.

Lawson was also responsible for significant innovation in Housekeeping, Laundry and Linen Services, and Food and Nutrition Services. Lawson believes Fraser Health has provided opportunities to grow within an organization he believes in: “I like the sense of working to support a social purpose and that our work enables people on the frontline to do their jobs. I like that Fraser Health works as a team to support the end goal – which is to provide excellent patient care.”

Unlike David Lawson, David Handley started his career as a health care professional. The British-born-and-raised Handley went through extensive physical therapy in his teens, which inspired him to pursue a career in health care. He graduated in Physiotherapy and went immediately into direct patient care. Like Lawson, Handley says health care fits within his value system – “I knew that I wanted to work clinically in health care because I believed in the benefits.” Both men understand how important health care is to people and how important people are to health care.

After emigrating to Canada, Handley continued his health care career in Alberta until he eventually made a dramatic career change and became Director of Human Resources. From that point on, Handley became increasingly interested in the business side of health care and developed a passion and skill for negotiating.

In 1999, he took on the role of Vice President of Operations for North Shore Health in charge of departments including Finance, Information Technology, Shared Services and the Laboratory. He later moved to Vancouver Coastal Health where he led the Value Improvement Network team, which focused on finding efficiencies in the system. In this role, Handley oversaw the successful
that the amalgamation is a “transformation and cultural change” for Fraser Health and VCH employees. Changing the organizational structure of Shared Services is essential to the amalgamation, but having the staff onboard and supportive of the new program is crucial as well. Lawson knows the importance of the people he works with. “My job,” he says “is to empower my people, to value and respect my employees, and to work with them on a collaborative level – and to expect results.” Despite all the changes, Lawson knows that it is important for everyone to “retain a sense of family in our workplace, but to realize that it is now bigger.”

Handley, equally emphatic, tells his staff that accepting change is an important part of growth. He believes “it is important to be engaged and to be honest with everyone. As well, it is imperative to be open to ideas and criticism daily and to be constantly looking to improve yourself and your team.”

Together, Fraser Health and Vancouver Coastal Health have taken the first step on a path leading to the creation of a larger program that will one day become a provincial initiative. The success of the amalgamation of the two Shared Services departments will likely drive more changes in the future, including the transition to the Provincial Shared Services Organization. Though still in its formative stage, the Shared Services Organization (SSO) is simply a much larger version of what has taken place over the last six months, within Fraser Health and VCH. Bringing together the Shared Services of all health authorities in BC will reduce system costs while maintaining, and hopefully raising, the quality, efficiency, and effectiveness of the services provided.

Although these changes have been virtually unseen by patients and most staff, they have had a dramatic impact on the future workings of the two health authorities. The amalgamation of Shared Services in Fraser Health and VCH, although challenging both structurally and culturally, promises significant benefits for the future. Despite the challenges they will face, both Davids believe the long-term benefits are worth it. “A dollar saved is a dollar for care,” says David Lawson.

For Fraser Health and Vancouver Coastal Health, the future holds the promise of many more dollars for patient care.

Expanding the sharing

The BC Health Authorities’ Shared Services Organization (SSO), a collaborative effort between the health authorities and the Government of BC, was launched last year to examine the feasibility of providing greater shared services to maximize available financial resources for direct patient care. As a start, the SSO anticipates savings of more than $150 million over five years by combining the buying power of health authorities across the province. The SSO is expected to assume responsibility for providing supply chain services for the health authorities early in 2009.

Experience and examples from other jurisdictions show that shared services will:

- Allow for economies of scale
- Free up resources that can be directed to patient care
- Open opportunities for career development and the retention of skilled employees
- Reduce duplication and consolidate systems and technology
- Ensure that the costs of doing business are transparent and equitable
- Promote a focus on customer service and performance management
Dr. Laura Duggan, an anesthesiologist, and perfusionist Dustin Spratt, have established a successful recycling program in the Royal Columbian Hospital Operating Rooms. Two years ago, Duggan and Spratt began working with cleaning staff to develop a system for separating plastics and paper for recycling. The program grew rapidly as it caught on with staff. “We did a lot of education with staff about what can and cannot be recycled, and the program grew nearly overnight from 10 bags a day to 30 bags. Now we’re up to 40 bags of recycling,” says Spratt.

Those 40 bags hold everything from packaging from gowns, syringe packages and syringe covers, plastic tubing, IV bags, metal suture coverings, suture packages to perfusion packaging from the open heart OR. Some of the plastics, such as the perfusion packaging, are considered “good plastic”, says Duggan and will be reused when the plastics undergo a second round of separations at the recycling depot.

“Dustin and I have both been involved in getting the OR recycling program going, but it would not have expanded and become such a success without all the staff in the OR joining us,” says Duggan.

“Many OR nurses have set up recycling bins in each of the ORs. Lolan, one of our general surgery nurses, collects all the soft clear plastics and quietly schleps them off to a recycling depot, and the cleaning people empty our bins at least four times a day- without complaint.”

One of the obstacles Spratt encountered when he attempted to expand the recycling program at RCH was that the demand for recycling services exceeded capacity. Spratt is looking forward to the development of an organization-wide recycling program. Mixed recycling, refundable container recycling and organic composting are all expanding and will soon go to RFP under the Mixed Recycling/Resource Management umbrella.

In order for the initiative to take hold, she worked hard to get several groups of people on board and spent countless hours of her own time organizing the program and educating participants. Her effort in putting a team together paid off. “What made it a success was how supportive everyone, including my manager, Rhonda Kremko, was in getting the program rolling,” adds Sherban.

She recently won a Fraser Health Above and Beyond award in recognition of her success.

In addition to extending the recycling program to the rest of the hospital, Sherban would like to see a move to green cleaning products, reducing mercury use in the hospital and increasing energy efficiency. Even simple things like turning off lights at night can help.

Sherban led the charge to get a Green Team formed at LMH, which had its first
As Fraser Health develops its own comprehensive sustainability plan, many enthusiasts in this organization couldn’t wait to get started doing their part to help us move to more sustainable, enviro-friendly practices. By Sandra Ramezani and Ellen Baragon

meeting last year, and included a sustainability expert who came to offer tips on how to go green in the hospital. Lisa Cheng, Manager of Food and Nutrition Services at LMH, is also on the Green Team and initiated the replacement of disposable aluminum pans with reusable ones, a simple measure that adds up to an estimated savings of between $7,000 to $8,000 annually for LMH.

“Aluminum disposables are neither environmentally-friendly nor cost-effective,” says Cheng, “and they don’t heat up food or clean up as well either.” Cheng says the changeover did not mean an increase in labour, and overall the cleanup process was successfully consolidated in a way that saves time and money. Cheng hopes the Green Team will aim to phase out bottled water in the coming year as well.

The dirt on composting

Belynda Penzer, Food Services project manager for Fraser Health, and head cook Heather Leason of Burnaby Hospital, tackled another great opportunity to reduce environmental impact at FH. They have been instrumental in introducing organic composting which will save the landfill tonnes of unnecessary garbage buildup every year.

For close to a year, Penzer reports, both Burnaby and Delta Hospitals have participated in recycling organic wastes, which includes trimmings from food preparation, as well as pulped paper products and discarded plants and flowers. The waste is picked up by a carrier which transfers it to a compost plant in Ladner. It is then converted into dirt that is used by a local turf farm.

Penzer says staff are adapting well to the green scheme. Penzer hopes organic composting will be expanded further throughout Fraser Health.

Leason says the key to making recycling programs work is to make the system easy for staff and to emphasize the positive benefits. “We’re just promoting this for our kids,” she says.

Burnaby’s green crusade

Jim Pound, Manager of Cardiology and Neuro-diagnostics at Burnaby Hospital, is co-chair of the Green Team, which last spring hosted a green fair in the cafeteria to both educate and inspire people on green alternatives. The fair included about 20 booths represented by a variety of organizations and businesses that featured some of the ways that individuals and organizations can make green choices. BC Hydro, for example, demonstrated how much human power generated from riding a stationary bicycle is required to power a light bulb.

Before he got involved at work, Pound says he was already committed to a more environmentally sustainable lifestyle. He points to many opportunities for Fraser Health Green Teams to make a difference. “Paper is the aspect we want to work on, although it is complicated due to the types of paper, the confidential documents involved, and so on. So that may take some time. We do battery collections and plastics recycling already here. But I think one of the keys is to build the infrastructure for recycling so that it is convenient for people to participate. That is when it will be the most effective.”

Pound says the Burnaby Green Team would also like to provide a forum to promote alternative modes of transportation so that staff can see the benefits of leaving their cars at home.

Coming soon: a green corporate health care plan

The chief financial officers from Vancouver Coastal Health, Fraser Health and Providence Health have recently signed a tri-party agreement acknowledging their commitment to work collaboratively on a unified Green Health Care Plan.

The primary goal of the agreement is to reduce our environmental impact and carbon footprint. Significant focus will be placed on reducing our greenhouse gas emissions as well as our energy consumption. All programs and services within each health authority will be responsible for identifying, developing and implementing their own environmental initiatives and will report their progress on a regular basis. Reports will identify initiatives completed within the last year, currently underway or planned for upcoming years.

The Business Integration and Support Services division will take on the central co-ordination role, with Kevin McClain assuming a new position of Manager, Environmental Reporting. Please contact Kevin at Kevin.mcclain@fraserhealth.ca if you have any questions about how to get involved or you would like to highlight a specific green initiative that you have undertaken or are considering.
From their new life in the State of Qatar in the Arabian Gulf, Fraser Health ‘alumni’ Dr. Peter Hill and Freda Betz Martin share their experiences of their journey of professional leadership, personal adventure and exploration.
This morning, Friday, December 12th, we started our weekend (Fridays and Saturdays here in Qatar) with a breakfast picnic on a grassy knoll overlooking the Doha Bay and its beautiful seven-kilometre oceanfront walking path, much like the Stanley Park seawall. The air temperature was a balmy 28 degrees, and a cloudless sunny sky smiled on local fishermen selling their morning catch from Arab dhows. The scene is a dramatic contrast against the backdrop of a modern-day city skyline boasting business towers of the most impressive architecture found anywhere in the world. The Friday ‘call to prayer’ from a local mosque hung on the morning breeze, causing us to reflect on how we had come to be here.

Freda and I first met up professionally when her team prepared to implement iCare in Delta Hospital, the pilot site of that promising new initiative Freda had co-created (see The Authors). I had quickly recognized the potential of the new work. Freda and I joined professional forces and enabled together this revolutionary initiative that effectively increased quality patient care while simultaneously reducing acute care decongestion. We both remain extremely proud of our involvement in an initiative that has spread to every hospital in Fraser Health as well as into Vancouver Coastal.

By late 2007, we were contemplating together an invitation to come to Qatar (pronounced KATTER) to a very different country, culture and health system. We believed that it was too great an opportunity to pass up, both professionally and personally, so here we are.

Coming here was a very big leap for us. We are living in the midst of predominantly desert, with one large urban centre in Qatar’s capital, Doha. The country’s wealth is mostly derived from extensive natural gas and petroleum resources. There are a few peripheral small towns and villages in the country, making the main community of Doha the centre of culture, as well as the main area of shopping, support services, and, of course, health care. There are about 1.7 million people here, of whom the expatriate group comprises about two-thirds; there are up to 70 nationalities represented in the workforce. The political system is expressed as a constitutional monarchy supported by an appointed prime minister and cabinet.

The landscape of life is also different in many respects. One of the first observations a newcomer would have is of the traditional national dress. Men wear a long white cotton robe, with white- or red-checked head coverings called the ‘Thobe’ and ‘Guttra’ respectively. I have not yet adopted that style for those of you who are trying to imagine me in that garb. But they say it is the best way to keep cool in the usually-stifling heat.

Traditional dress for Qatari women is an all-black wrist- and ankle-length robe, the Abbayah, typically with a black head scarf covering the hair. Some women also wear the traditional veil. (No, Freda has not adopted either look.) This universal national dress code is a mixture of religious and cultural tradition. Western women, and women from other cultures, dress much as they would at home, but with an added conservative respect for local culture.

The most remarkable aspect of the Qatari culture is the thoughtful gentleness of the people. It is humbling to witness their ready acceptance, and integration of, the more than 70 distinct cultures of people living and working side-by-side in this tiny country.

Our employer, Hamad Medical, is the only public provider of health care for the nation, which, apart from a small attendance fee for non-Qataris, is free. The system is globally funded by government but in the near future will likely migrate to an insurance coverage-based model. There are five large hospitals, with three new ones under construction. The major hospitals have substantially greater capacity and workload than those in Fraser Health. For example, the national maternity hospital delivers 15,000 babies annually.

Hospital congestion is a global issue from which Qatar is not exempt. In spite of ready access to financial resources, staffing is the primary constraint to alleviating congestion. Hamad is part of an academic teaching system in partnership with Weil-Cornell medical school, as well as other North-American health and academic organizations.

Freda is the Executive Director of the newly developed ‘Centre for Health Care Improvement’, the corporate catalyst for improvement in operations and best business and clinical practices. There are currently around 35 projects in line.

My role is corporate Medical Director, which means an oversight responsibility.
for the quality of health care provided by around 2,000 Hamad medical staff. Is managing doctors any easier in Qatar than in Canada? There’s no question that experienced western leadership can be helpful here, but there is equally a great deal to learn from what has been achieved in Qatar, and also from a richly experienced and diverse workforce. The physician workforce is salaried and, just as occurs elsewhere, we are challenged to recruit experienced specialists from some disciplines. Despite the absence of local taxes, not everyone wants to live in the midst of a desert and 50-degree summers.

Following our picnic this morning, we packed up our muffins and coffee into our safety-first 4-wheel drive and set off through the ‘war-zone’ that is traffic flow in this city. If you think that driving in Vancouver is a problem, by contrast it is positively sedate and you are all incredibly fortunate.

You take your life in your hands on the roads here. The culture has apparently not yet fully transformed from unstructured desert travel to an adherence to white lines and blacktop. As we drove through the city, vehicles were racing and switching wildly between lanes. Where the marked lanes don’t accommodate drivers’ needs, they just create alternative lanes spontaneously! It’s a nightmare.

It takes forever to learn your way around the city: when driving, your eyes are fixed firmly on the vehicles around you – there isn’t a second to look for city landmarks. I bought a GPS just to get us home! Not only that, there are no house numbers in the streets and sometimes the streets are unnamed, so an ‘address’ is an interesting concept. Directions are mostly aided by travel between nickname roundabouts. For example, you might receive these instructions: “From ‘coffee pot roundabout’, go to the ‘clock roundabout’, and you can’t miss it” – which of course we always do!

In terms of everyday living, you can find and buy most things that you could in Canada. One of the many contradictions of life in Qatar is that we can readily find any modern day superlative like Dior, Harry Winston, Louis Vuitton etcetera. But we may have to go to three different supermarkets to find certain basics. There are some things you just cannot find, like whole wheat flour or a real bagel.

Then there’s the heat: it is both an art and a science to live in 50-degree temperatures in August, with five-minute summer heat-exposure warnings. Our backyard pool is actually artificially cooled during the hot summer months.

Among our reasons for coming here was to experience the desert, and to travel. We recently took a one-day four-wheel-drive trip through the desert with Freda’s visiting daughter. It was amazing – up and over spires and edges of rolling desert dunes, just sand as far as the eye could see. After about 30 km, we arrived at an inland ocean fjord – white sand beaches and warm clear ocean… it doesn’t get any better. We spent the evening riding camels and then relaxing on low Bedouin-style cushions, enjoying a traditional desert camp meal while listening to hypnotic Arabian music.

Since we do still work for a living and do not spend all our time picnicking and travelling, perhaps we should tell you about some of our professional challenges. The traffic scene I described results in a significantly high incidence of trauma, particularly to young males and unrestrained children. A consequent challenge is an under-developed rehabilitation system. The pace of corporate construction is frenetic; 85% of the world’s large cranes are in Qatar, in a workplace that is just learning about the kinds of safety measures we rely on in Canada. There are 140 beds in our main emergency department, one of the world’s largest, which serves a very high incidence of industrial trauma.

Childbirth here is a significant social celebration. Some prominent families literally move their furniture, beds, couches, and huge flower and chocolate celebrations into their hospital rooms. At the Centre for Health Care Improvement, Freda and her team are designing separate elevator and access doors for these deliveries in order to reduce the extreme congestion at the entranceways to the hospitals. ‘Length of stay’ brings out interestingly different cultural concepts here … for instance LOS can be dependent on whether family members have had the opportunity to visit and celebrate the birth.

Our journey to Qatar has been the gift of a lifetime, both professionally and personally. No doubt there are obstacles every day at work and in daily life… but frankly it is exciting to confront challenges that are new to us. No longer is every professional decision dictated by funding: The Qatar Foundation currently has over $8 billion in reserve! This endowment from the Throne is specifically designed to sponsor excellence in health care and health care research. The challenges here, however, do demand of us to be both creative, and at the same time respectful of a profoundly unique history and culture in order to solve them.

We find ourselves happily, and at times a bit obsessively, immersed in solving the professional puzzles set in the contradictions that are the fabric of modern day Arabia. While the demand side of health care is not too dissimilar from that in Canada, one predominant difference in the supply side is the historically traditional and tribal process for arriving at a map of solutions. Various individual or group interests, therefore, can quickly overtake each other in a very short time frame. This can leave the western health care executive occasionally quite confused compared with our own backgrounds of structured strategic planning.

All of this provides us with a tremendous learning opportunity in the different ways of the world and it is an honor and a privilege to be here.
0645: I walk up to the door and I feel my heart beginning to beat stronger and faster. I’m about to enter the hospital and make my way to the maternity floor where I will begin my new job as an Employed Student Nurse (ESN).

In British Columbia, student nurses are registrants of the College of Registered Nurses of BC. As ESNs we have the opportunity to consolidate our current learning while working under the supervision of a Registered Nurse.

0700: I eagerly wait for the staff to arrive so we can begin our shift report. I am so excited to be part of the team and to take part in report. Which nurse will I be assigned to today? What kind of patients will I have? I wait in anticipation. Interesting cases today: caesarean, vaginal deliveries and pre-term babies. A baby is being delivered at this moment… how exciting; someone is giving birth to a new life. I love my job already!

0720: Sitting quietly in the corner, thinking that I know exactly what’s going on… the charge nurse for the day asks “Are you new to the floor?” I reply, ‘Yes, I am the ESN! Today is my very first day.’ The charge nurse replies, ‘Great! We can use the extra help!’ The nurses all welcome me and tell me how excited they are to have me here. I am paired off with a RN to shadow for my first day.

0745: The RN I have been paired with shows me where I can find all the things I need to begin my day. I observe how she prioritizes her workload. Note to self: ‘I can use this in my own practice when I graduate.’ We locate the thermometers and stethoscopes. The baby stethoscopes are so tiny compared to the adult ones I’m used to. Just as we are about to sit down so I can ask questions, a bell goes off. The nurse quickly gets up and tells me to look over the new employee manual while she’s gone.

0815: The nurse returns and asks if I would like to sit with the new mom in the room across the hall because her family is unable to be here with her. Wow, here is an opportunity for me to make a little difference. I can put into practice what I learned in my training.

0820: I walk into the new mom’s room and find her crying. ‘You seem upset; would you like to talk about it?’ Between her sobs, she explains: ‘It’s just so hard, in my culture we have our family around us for support; I feel so alone in this country.’ I sit and listen to her and then offer her my support. Am I ever thankful I paid attention to the nursing class in culture and sensitivity! I suggest some local resources for her to access; and she is very grateful to have someone to talk to.

0845: After I leave her room my RN and I begin rounds. Within minutes she bonds with her clients while doing a head-to-toe assessment, inspecting mom’s IV lines and checking on baby, of course. I hope I become as proficient as she is. One more year left of nursing school and I am on my way. I will use my knowledge, skills, abilities and critical thinking when promoting health and well-being to patients.

0900: It’s coffee break time and the nurse tells me she will be joining me as soon as she’s finished with the morning assessments. I go to the staff room to have my morning coffee.

1000: Finally, I get the chance to do some hands-on work. The nurse asks if I am comfortable doing the baby’s first three set of

Fraser Health recruits ESNs year-round

Professional Practice’s Practice Start program provides an opportunity for third- and fourth-year nursing students to gain paid practical job experience before graduation. Fraser Health hires student nurses who are starting third or fourth year of their nursing education (4th year for UBC) and accepts applications year-round.

The Employed Student Nurse (ESN) program has been developed to foster:

Practice Readiness
- Advancement in clinical decision making and assessment skills
- ESN’s ability to practice with increasing confidence

Job Readiness
- Increased familiarity with routines
- Interdisciplinary collaboration leading the ESN towards the graduate role
vitals. YES! Then I think to myself, I am ready, aren’t I? Well, either way, here goes. I enter the room and introduce myself to the family. They all look so happy to have this new addition. I look over at the new father’s dazed-looking face and reassure him it won’t always feel this overwhelming. I take the baby’s vitals and record them on my paper to put into the chart. I congratulate the family and tell them I will be back in one hour to take the next set of vitals.

1030: Another bell is ringing; I go with the nurse to see what’s going on. The mother looks upset, and the baby is crying. She thinks her baby is not getting enough milk. The nurse is amazing with her. I see how the nurse builds confidence within the new mother and how rewarding that must feel to help and teach.

1100: Oh no, I almost forgot about the second set of vitals. I go to grab the thermometer and stethoscope but I can’t find them anywhere. I guess they must all be in use. I ask one of the nurses where I can find one and she points to the assessment room. Thankfully I find one; I don’t want to miss anything on my first day.

1200: It’s time for lunch already. I help hand out the lunch trays to all the moms and go for my lunch break as well. I sit in the staff room wondering where the morning has gone.

1300: I’m sitting at the desk looking over the chart of the baby’s vitals I have recorded; I want to make sure I’ve done this correctly. I must look at it a dozen times before I decide it is correct and finally put the chart away. I want to make sure there are three consistent sets of vitals before the baby has its first bath.

1330: The nurse asks if I have ever done a baby bath before. I have and ask if there is one to be done. I’m hoping she’ll say yes. She would love the extra help she says.

1400: I’m really nervous. What if I take too long and the baby’s temperature drops? What if the parents ask me questions I can’t answer? I’ve done this before in nursing school. The tubs haven’t changed in the last 10 months, have they? No… okay… my nervousness subsides.

1500: I get to do a baby bath with mom, dad and the RN as my audience. This is a bit nerve-racking, but after it’s over the RN tells me I did a great job and that makes me feel good. The parents were wonderful and very thankful for my assistance in teaching and demonstrating to them how to care for their baby.

1600: I sit down at the nurse’s station and start to read through the manual again. As I begin to get through the first few pages, one of the nurse’s approaches me: ‘So, I hear you’re pretty good at giving baby baths,’ she says. I ask if she would like me to give another bath, hoping she’ll say yes. She would love the extra help she says.

1700: I’m sitting in the staff lounge, eating my dinner and I begin to realize how great an experience this is. I love working with families and new parents because it’s great to see them grow in knowledge and experience in caring for themselves and their babies. I am having an amazing day so far and it is only my first day. I take a few minutes to call home and check in with my family.


1800: I meet with the charge nurse to tell her how my first day went. I tell her my day was filled with an array of emotions and opportunities to build on previous nursing experiences. I am excited to be a part of the wonderful team on the maternity unit. I was grateful for the privilege to spend time with one of the new moms and help her find some resources. I hope this will help her adjust to being so far away from her family.

1830: I see the night staff coming onto the floor with their snacks in hand. With three calls coming in for deliveries, it looks like its going to be a busy night. Soon, I will know what it is like to work the night shift.

1900: My first day as an ESN is complete; it’s official, I am now an employee of Fraser Health and a part of the maternity unit team. The nurses thank me for all the help I provided; it feels good to be appreciated. I thought I was taking up their time, but they were all excited to have me there. I feel fortunate to work in a learning environment with such talented and educated professionals. As an Employed Student Nurse, I have a wonderful opportunity to enrich my skills and knowledge to become a competent nurse when I graduate. One thing I know for certain is that I love my job as an ESN and I am thankful to have this opportunity.
“Ballroom dancing is an opportunity to do something totally different from the rest of my endeavours and it gives me an opportunity to share time with my wife.”

Gordon Barefoot
Chairman, Fraser Health

Gordon and Cheryl Barefoot tango their way around the dance floor at the Arthur Murray Dance Studio in White Rock. Devotees of ballroom dancing for the past 2½ years, the couple strut their stuff at least twice a week, either at a lesson or a social evening. They even competed at the beginner level in Las Vegas and Hawaii.
DON'T LET REUSABLE ITEMS GO TO WASTE. REGISTER TO BECOME AN ORGAN DONOR TODAY.

transplant.bc.ca