Mental Health Program/Department of Psychiatry Operational Approval for Research

The survey will take approximately 9 minutes to complete.
Summary of Proposed Research for Operations/Program Leaders

* Required

1. Principal Investigator: *

2. Study Title: *

3. Name and e-mail of Primary Contact Person for the Research:

Research Summary

4. Summary of Research (do not exceed 250 words) *

5. Proposed Process for Obtaining Consent:

6. Expected Start Date: *

📅

Format: M/d/yyyy

7. Expected End Date:

<table>
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Format: M/d/yyyy

8. Areas of the Mental Health Program where the study will be carried out (select all that apply): *

- ☐ St. Paul's Hospital Inpatient Units (2N, 8C, 9A, PASU)

- ☐ 2N

- ☐ PASU (2E)

- ☐ 8C

- ☐ 9A

- ☐ Brief Intervention Clinic

- ☐ Reproductive Psychiatry Clinic

- ☐ Mount Saint Joseph's Geriatric Psychiatry - 1South

- ☐ St. Vincent Langara - Alder

- ☐ Parkview

If other please specify:

Staff Impact

9. Will mental health program employees be required to collect any data beyond what is collected for routine clinical care? *

☐ Yes

☐ No

10. If YES to Q.9 please describe:

[ ]

11. Are any of the study procedures planned for times outside of daytime hours (0700-1600, Monday to Friday)? *

○ Yes

○ No

12. If YES to Q.11, indicate days of week, times and expected frequency:

[ ]

13. Will mental health program employees be required to enter data into study databases? *

○ Yes

○ No

14. If YES to Q.13 indicate amount of time estimated to complete:

15. Are nurses, physicians or other mental health program employees subjects in the study? *

○ Yes

○ No

16. Does the research protocol require any nursing or allied health services? (vitals, specimen collection, assessments, etc.) *

○ Yes

○ No

17. If YES to Q.16 list all tasks required:

18. If applicable, outline how you will provide information to nursing or other unit staff about their role in the study. Consulting the clinical area leader is recommended for more complex protocols.

Impact on Resources

The Program will determine if the required services necessitate recovery from the study budget to offset costs. The Program leader will provide investigators with the cost of these services.

19. Is the study funded? *

○ Yes

○ No

20. If YES to Q.19, indicate source of funds:

[   ]

21. Will the study will result in additional costs to the program/unit, e.g. equipment, supplies, personnel. *

○ Yes

○ No

22. If YES to Q.21, please describe:

[   ]

23. Will additional costs be covered by the study?

○ Yes

○ No

24. Your research plan must include at least one knowledge translation (KT) activity. Describe the KT activities planned for staff and leaders in the MHP:
    *

Agreement

We reserve the right to review our continued involvement in your study and may require additional approvals if the study timeframe, budget or related activities impacts the program/department beyond what is outlined in this application.

Your research plan must include at least one KT activity (e.g., report, workshop, presentation, educational material, etc.) for MHP program staff and leadership.

The PI is responsible for providing the Research Committee Chair with copies of Certificate of Ethical Approval and the PHC Institutional Certificate of Final Approval.

Review and operational approval will be provided within 2-4 weeks of submission.

Send Completed forms to: arussolillo1@providencehealth.bc.ca