Quality Initiatives

Entries in the 10th Annual ACHS Quality Improvement Awards 2007
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Category: Clinical Excellence and Patient Safety

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Royal Children’s Hospital – Melbourne, Surgery Program, Parkville, VIC

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Royal Brisbane and Women’s Health Service District (RBWH HSD), Department of Social Work Services, Herston, QLD

A Question of Safety, Hydro, Hypos and Heat
WACHS – Great Southern Community Health, Population Health, Albany, WA

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Dual Source Computerised Tomography Scanner
Sydney Adventist Hospital - San Radiology, Wahroonga, NSW

Early Recognition of the Deteriorating Patient Project
ACT Health, Patient and Safety Quality Unit, Woden, ACT

eLearning: Providing a Flexible Environment for Ongoing Professional Development in the Healthcare Setting
Calvary Health Care ACT, Emergency Department, Jamison Centre, ACT

Embedding an Evidence Based Treatment and Best Practice Service Model in Psychiatric Services
Ballarat Health Services, Psychiatric Services, Ballarat, VIC

Emergency Department Case Coordinator
The Valley Private Hospital - Allied Health & Emergency Departments, MULGRAVE, Victoria

Evidence based Management Guides for Clinical Practice
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Southern Health, Quality Unit, Clayton South, VIC

The Physiotherapist-led Orthopaedic Assessment Clinic (OAC)
Royal Children’s Hospital – Melbourne, Surgery Program, Parkville, VIC

The Sister Francesca Healy Cottage
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The Western QUATRO Project
Barwon Health, Community and Mental Health, Geelong, VIC

Using Client Self-Report of Psychological Distress / Symptomatology to Improve the Effectiveness of Psychological Interventions
Greater Newcastle Cluster Hunter New England Health, GNC Psychology, Newcastle, NSW

Well-tel: an Alternative Model of Care
Royal Perth Hospital, Rehabilitation & Orthopaedic, Shenton Park, WA

Category: Non-Clinical Service Delivery

Winner

Cancer Patients’ Legal Assistant Program
Peter MacCallum Cancer Centre, Social Work Department, Division of Hematology & Medical Oncology, Melbourne, VIC

Submissions

Aboriginal Health Service Development and Partnerships
Southern Health, Quality Unit, Clayton South, VIC

An Integrated, Online, Credentialling and Defining Scope of Clinical Practice System for Senior Medical Staff
Southern Health, Quality Unit, Clayton South, VIC

Area Governance Manual
South Eastern Sydney Illawarra Area Health Service, Executive Support Unit, NSW

AUSLAB Pathology Project
Royal Brisbane & Women’s Hospital, Health Information Services, Herston, QLD

Cleaning Project
Northside, Northside West and Northside Cremorne Clinics, Greenwich, NSW

Creating an Integrated Award Winning Total Safety Management System
Bentley Health Service, Safety and Quality Unit, Bentley, WA

Effective Management of Clinical Equipment in a Rural Area Health Service
WA Country Health Service- South West (WACHS-SW), Bunbury, WA
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Category: Health Care Performance Indicators

Winner

Pre Hospital Acute Triage: Translating Evidence Intro Practice by Improving Patient Access to Acute Stroke Care
Hunter New England Health, Medicine / Department of Neurology, Newcastle, NSW

Submissions

Clinical Indicators
Kerala Institute of Medical Sciences, Trivandrum, Kerala, India

Clinical Indicators in General Medicine
Southern Health, Quality Unit, Clayton South, VIC

Embedding a Performance Culture in the Hornsby Ku-ring-gai Health Service (HKHS) Emergency Department (ED)
Hornsby Ku-ring-gai Health Service, Medicine, Emergency Department & ICU Hornsby NSW

General Medical Indicators Program (GMIP)
Melbourne Health, Clinical Epidemiology & Health Service Evaluation Unit (CEHSEU), Department of General Medicine, Parkville, VIC

Indigenous Cardiac Outreach Program
The Prince Charles Hospital, Cardiology Unit, Chermside, QLD

Performance Indicators
Kerala Institute of Medical Sciences, Trivandrum, Kerala, India

Risk Matters – Cultural change facilitates successful development and implementation of a risk management system in a private health care organisation
St John of God Health Services, Burwood, NSW

The use of Clinical Indicators to Monitor and Improve the Quality and Safety of Care
Southern Health, Quality Unit, Clayton South, VIC

Using a PDSA Cycle to Improve Patient Health
Department of Corrective Services - Health Services, Greenough Regional Prison Health Centre, Geraldton, WA

Student Award
Bachelor of Medicine, University of Newcastle

Pre-transfusion requests: the (legally binding) pathology form
Burgess L, Williams M, Zawada KA
Clinical Excellence and Patient Safety
Day Procedures for Children requiring Lumbar Puncture and Bone Marrow Aspiration at the Royal Children’s Hospital, Melbourne

Royal Children’s Hospital – Melbourne, Surgery Program, Parkville, NSW

Author
Dr Catherine Crock
Physician, Division of Laboratory Services and Centre for Adolescent Health

Aim
To provide a service that reduced the overall anxiety, distress and pain felt by patients and their family members due to lumbar punctures and bone marrow procedures.

Abstract
How was it before? The Day Procedure Lumbar Puncture and Bone Marrow Aspiration list provides a pain free option to children having repeated treatments or tests necessary in the treatment of cancer. We aim to make the admission into the day procedure unit relaxed and comfortable, and to ensure that the child and their family feel supported through their treatment. The Day Procedure list, performed within the Day Surgery theatre, is staggered to reduce long waiting times. Music therapy is provided in the waiting room and special CDs have been produced for use in the procedure room to help reduce anxiety or boredom. Children no longer require restraint for these procedures and they no longer have pain associated with the procedures. The result is that children and parents are less fearful of coming to hospital for these and other procedures. In addition, parents now have the option of leaving the department for a break, taking a Parent Pager with them so that they can be called back to the recovery area when the procedure is completed. Over the preceding two years, we have engaged parents and staff in helping to improve our service. This has led to an increase in the use of music, implementation of a Parent Business Centre and exercise equipment for the use of parents. A recent review of the Lumbar Puncture and Bone Marrow Aspiration list and the use of Parent Pagers within the Day Procedure and Day Oncology units was undertaken with favourable results obtained from parent feedback.

Introduction
Children with cancer being treated at the Royal Children’s Hospital were previously required to undergo Lumbar Puncture and Bone Marrow Aspiration procedures in treatment rooms in the ward areas. Undertaken in this manner, the procedures were painful and distressing for both the child and the parents. At times, children required restraint during the procedure which in turn affected the child’s trust in the caregivers. This method also appeared to exacerbate the needle phobia some children develop during the course of their treatments and many children and parents suffered raised anxiety levels in the lead up to the procedure.

It became evident that this was less than ideal for our patients, their family members and for the healthcare professionals involved. A review of the literature found evidence of long term psychological effects for children having repeated painful procedures. In addition, it was established that some other children’s hospitals were in the process of reviewing and altering the use of sedation and analgesia for these procedures.

Our aim was to provide a service that reduced the overall anxiety and distress felt by our patients and their family members and to reduce or eliminate pain related to the procedures. To achieve this, the Lumbar Puncture and Bone Marrow Aspiration procedure list was introduced into the Day Procedure Unit of the Royal Children's Hospital, which would enable children to undergo these procedures in a pain free and family-centred environment. The introduction of Parent Pagers in 2005 has provided additional freedom for the parents and family members who are now able to
leave the department without fear of the staff being unable to reach them when their child’s procedure is completed.

Method
A working party was formed to undertake literature searches and to develop a plan for providing an improved service in line with our aims. The working party made contact with all other Australian children’s hospitals to obtain information regarding their management of these procedures. Discussions were held with the Royal Children’s Hospital Anaesthetics department and Intensive Care Unit and the Alfred hospital in Melbourne to establish the most appropriate type of anaesthesia for repeated short procedures in this particular patient group, taking into consideration the longer term nature of the need for the procedures.

To obtain a more focused response a questionnaire was developed with questions relating to the experiences of our patients and their families with particular emphasis on the amount of distress, anxiety and pain suffered before, during and following each procedure. A 92% response rate provided the working party with an exceptional information from which a plan of action could be developed. The results of the audit were presented at a meeting of the Royal Australasian College of Paediatrics.

A specific outcome of the study showed that, given the choice, 90% of parents and children would prefer to undergo these procedures under a ‘light’ general anaesthetic. Providing this option appeared to be a key component to improving the manner in which the procedures were undertaken and therefore the outcome for our patients and their families.

A second element of this initial review involved the healthcare personnel working within the area. Some staff, initially uncertain that this change was necessary, were convinced once they came to work on the list. This in turn led to a more consistent team of medical and nursing personnel working within the department as well as a more stable and familiar environment for our patients who return on a regular basis for their procedures.

The process commences when parents are contacted by the Oncology coordinator and booked onto the list a week before. The day before the procedure date they are telephoned and given fasting instructions. Some of our patients also receive chemotherapy during the procedure. Oncology personnel liaise with the Pharmacy department to ensure that the chemotherapy is delivered with the patient file on the day. The laboratory services department ensures that all blood tests results are available in time for chemotherapy to be written up for the list.

Admission times are staggered to eliminate long waiting times and unnecessary anxiety and to fit with the family’s other commitments. The families arrive and are greeted by a familiar Admissions clerk, the Oncology Nurse, the Doctor from Laboratory Services who will perform the procedure and the Anaesthetist. A waiting area is provided where the children, siblings and parents are entertained by a Music Therapist and toys and games are available for patients of all ages. If there is an unavoidable delay, this is explained to the parents, and they are offered a Parent Pager, allowing them to leave the department until they are required for theatre.

When it is time for theatre, the child walks into the theatre with their parents, who stay with them until they are anaesthetised. The family is greeted by relaxed and familiar faces in casual clothes. The children’s hospitals Hush Collection CDs are playing in the theatre throughout the admission and the procedure. The first of this CD collection was produced specifically for the Lumbar Puncture and Bone Marrow Aspiration procedure list with music designed to calm and soothe. There are now 6 CDs in the collection, which are sold in many outlets and via a dedicated website. The Hush CD project has forged a unique collaboration between 12 children’s hospitals and wards in Australia with proceeds from the sales being used in clinical pain management and research.
We acknowledge there are very few choices available to children during cancer treatment, so we provide them with a selection of flavours for their anaesthetic mask, a choice of music and a choice about whether they sit in a chair, in their parent's lap or on the bed. Once the child is asleep the parents are shown to the waiting area where they can have a drink or snack or leave the department with a Parent Pager, knowing they will be called back to the department when the procedure is completed.

Although called the Lumbar Puncture and Bone Marrow Aspiration procedure list, the opportunity is taken to perform other procedures whilst the child is asleep. These may include blood tests, insertion of intravenous lines, accessing a subcutaneous port or Hickman’s catheter, taking a skin biopsy, insertion of a naso-gastric feeding tube and dental, eye or other examinations. It is therefore vital that the collaboration with other hospital departments and personnel is undertaken in an organised and systematic manner to ensure smooth running of the list. Any specimens collected during the procedure are taken to the laboratory where they are assessed as quickly as possible to enable results to be available to the parents as soon as practicable.

Following the procedure the child is transported to the recovery area just outside the procedure room, where the parents may sit with them as they wake. Within twenty minutes following the procedure, the child is normally fully awake and pain free and able to be discharged. The parents are then given discharge instructions prior to leaving the department. The list is a highly efficient and cost effective service. 12 children can receive complex tests each 4 hour session. When performed in ward areas or main theatre these procedures are much more time consuming taking around one hour per procedure.

Many personnel and departments work seamlessly to ensure that the Lumbar Puncture and Bone Marrow Aspiration procedure list is a success. This includes personnel from the Oncology department, Laboratory services, the Anaesthetics department, Day Surgery nursing and allied health personnel, Admissions department, music therapy, pharmacy and parents. Staff working on this list find the work extremely rewarding and are motivated to continually look for ways to improve what we do for families. The list is also a valuable teaching resource for the hospital with medical, nursing, allied health and many visiting staff from other institutions welcomed. A teaching video was produced to demonstrate the safe and efficient performance of Lumbar Puncture for medical staff.

The Lumbar Puncture and Bone Marrow Aspiration list has continued to evolve. Parents, children and staff have always had a say in the process, and continue to provide valuable verbal and written feedback. Parent feedback has been the single most important factor in our improvements to the service over the past three years, including the development of a new ‘procedure documentation’ form and a video to show new families what to expect when they come for their procedures. (“Meet the Experts” – an innovative video filmed from a child’s point of view using humour)

A review of the processes, including the use of the Parent Pagers, was undertaken in May 2007. The original questionnaire was revised to enable a more focused approach and a second questionnaire developed that related specifically to the use of the Parent Pagers. The evaluation of the procedure list provided an opportunity to establish a baseline level of satisfaction of those patients and their parents who have now undergone more than one episode within the department, with the range of admissions from two to several. All respondents stated a zero level of anxiety prior to the procedure, as they were aware of how the admission would flow and what to expect. In addition, all respondents stated a zero score for pain following the procedure. Further questions relating to the provision of information from nursing and medical staff received good or excellent rating, whilst the ability of staff in the procedure room to help the patient and their parent feel calm and relaxed scored ‘good’ from all respondents.
The aim is for this audit to be ongoing and to provide regular feedback to staff, patients and their families about the overall satisfaction relating to our processes.

A second review was undertaken relating directly to the use of the Parent Pagers. This system was introduced into the hospital following the generous donation of the pager units from the parent of one of our patients. The Parent Pagers are a convenient, simple and cost effective method of contacting parents around the hospital. An important benefit of the pagers is that their use has enabled the hospital to cease overhead paging of families which had enormous patient privacy implications.

Parent Pagers allow parents to wait elsewhere in the hospital, such as the cafeteria or the garden, whilst procedures are being performed and then be ‘paged’ back to the unit when needed. This allowed an unprecedented amount of freedom to our parents who could use the opportunity to take a break, care for other children or use the facilities available within the hospital. Although initially used in the Day Procedure unit, the idea has been repeated in other areas in the hospital. Feedback parents also led to the innovative step of developing a business centre and exercise equipment for parents.

The audit focused on two specific areas of the hospital where Parent Pagers are used – the Day Procedure unit and the Day Oncology unit. The questions related to the concept of the Parent Pagers in general and how easy or useful the parents found them. 73% of respondents found the pagers very useful, whilst 27% found them useful. 55% found the pagers very easy to use, with 45% finding them easy to use. Many parents made comments which included “great idea, very easy to use”, “it means that we don’t have to wait in the unit” and “it gives us the freedom to move around”. One parent commented that their child actually enjoyed wearing the pager around their neck whilst moving around the hospital!

This baseline audit enabled us to obtain valuable information about how we can improve on the use of the Parent Pagers. As with the procedure list, we aim to continue this audit so that we can provide feedback to our end users and where necessary, provide further assistance to our staff.

Throughout the ongoing development of the Lumbar Puncture and Bone Marrow Aspiration list, including the use of the Hush Collection CDs and the Parent Pagers, the highest priority and most important aspect has at all times been the focus on our patients and families. Our initial aims were, and remain, the provision of a patient-focused service that will reduce the overall anxiety and distress felt by our patients and their family members and to reduce or eliminate pain related to the procedures. At this point we feel that we are achieving these aims, however keeping in mind at all times that continual improvement is our objective.

Attached
- Parents letters:
  - Anon
  - Claire Kennedy
  - Burzloff family
- Letter of support from Dr Brandao – Toronto Hospital for Sick Children
- Results of Royal Children’s Hospital Parent Pager Evaluation – Parents / Others undertaken May / June 2007
- Photos
- Attached separately
  - DVD – Essentials of Lumbar Puncture Technique
  - Volume 3 – Hush collection
  - Information on the Hush Collection, Volume 5
Parent Letter 1

Our world came crashing down when our only child Emma, was diagnosed with ALL at the tender age of 5. As treatment commenced it became very apparent that Emma was not going to cope easily with the procedures she was forced to endure daily. When the time came for her first bone marrow aspiration it was obvious it was impossible for her to lie still for the procedure; despite medication; due to her utter terror. It was this day we were first introduced to the Day Surgery team and Emma’s coping treatment began.

There are many reasons that this system works so flawlessly. One being continuity of care. The nurses that Emma became familiar with and trusted from the ward, 6 East and outpatients were her first contact in day surgery.

Admission forms and medical records were ready and waiting for our consent. An anaesthetist would come (firstly “George” then “Rob” then “Michael”) and have a “chat” with us whilst determining Emma’s preferences for flavour of anaesthetic gas. The mood was always professional and congenial – to alleviate both parent’s and patient’s fears. An interview with the doctor (usually Dr. Cathy) doing the Bone Marrow Aspiration and/or Lumber Puncture procedure followed. Again an air of upbeat professionalism was employed, the doctor being at pains to offer Emma a choice with the procedure. Through the instigation of Dr. Crock the addition of a music therapist to the Day Surgery waiting room was a God send. Initially a worried and frightened child, Emma looked forward to the Day Surgery waiting room as an opportunity to sing songs and play instruments with “Beth”, whom she had met on the ward previously. We cannot begin to describe the huge improvement in Emma’s attitude once she began spending time with Beth. Music proved to be an excellent outlet for her fears.

Upon entering the theatre Emma would be greeted by Sonia or Gipp (from outpatients) and would be encouraged to sing along to her music selection as she went to sleep holding the mask to her own face. As a parent it’s the most difficult thing to leave your child in the hands of others, but the faith we had in this team of people would grow with each visit. Their expertise and professionalism left no doubt in our minds that our precious child was in the safest and most caring hands. Sitting totally relaxed in the waiting room we would often see “new” parents stressed with worry over their child’s first LP. We would assure them “this team are the best and to be trusted completely”.

Minutes later Dr. Cathy would reappear and reassure us that everything had gone well and that Emma would soon be in recovery. Once in recovery Dr. Cathy and the anaesthetist would always again check in on Emma to make sure she was okay. Emma would often wake in a very agitated state and thanks to this follow up we were able to adjust her medication to allow a smoother transition and happier child.

The flow of information between departments along the procedural path was fantastic. Everyone knew the patient, the diagnosis and the steps taken to make them well again. We were long-time consumers of the Day Surgery team. They made a frightening set of circumstances bearable with their humour and professionalism. From remembering to ask and include Emma in all decision making to providing the distraction of a music therapist the team provided outstanding care above and beyond what would be considered standard practice.

For a child to relax, they need to feel safe. Children feel safe with people they are familiar with, trust and like. This is how the RCH Day Surgical team has successfully turned our child around into a coping, healthy, happy person. For this we will always be hugely grateful and hope they continue this wonderful program for many years to come.

(From the mother of Emma)
Parent Letter 2

To Whom It may Concern, June 2007

The Parents Pagers were introduced on the Oncology ward at The RCH by Orange. They heralded a change in the way the medical, parent and patient relationship was managed. Up until this time the parents and patients were forced to wait in overcrowded and non-friendly family environments for hours on end to see their specialists and then to receive the treatment.

When the pagers came so did a change to our days at the hospital (which at any time could be every day in one week for month’s one end). One many occasions we as a family left the day patient unit after registering with the oncology day team support and upon awaiting treatment and our appointment time with pager in hand. When our time came the pager would beep through with a message and we would come back to the ward and get on with the business of saving our child’s life.

The difference that these pagers made was the simple reality of allowing families and individuals to reclaim a level of everyday normalcy within an environment that was so foreign and abnormal.

Well done as these pagers bought about a shift in the cultural thinking of what families need to successfully be together as one of the key indicators of the reality that endures our children to live through the dreadful treatment of cancer.

Claire Kennedy
Mother of a 6 year old Girl
Currently 4 years since diagnosis and still in remission (yippee!!)
To whom it may concern,

I would like to express to the hospital my gratitude for providing such a friendly space for my family when we come into day surgery. My 3 year old daughter Charlotte was diagnosed with leukaemia in January 2006 and since then we have endured at least 18 lumbar punctures.

Obviously this has been an immensely stressful time but watching your child have multiple general anaesthetics is the most difficult. Having to encourage a 2 and now 3 year old to come in for them has also been hard.

Having friendly staff who are usually the same who come and talk, explain and reassure every time even though they know you have heard it all before is really helpful. Their level of care and respect makes a difficult experience feel more familiar and less frightening.

The most significant of all has been the music therapy provided in the waiting room. Charlotte loves seeing Beth and actually looks forward to it. As you can imagine, this has made a huge difference to her stress levels, and also to ours, as her parents. Instead of sitting in fear and anticipation as a family we are dancing, drums and singing “Bob the Builder”.

Not only does Beth provide group music in the
waiting room, but when Charlotte asks her, she accompanies Charlotte into the surgery and sings with her until she goes to sleep. This has been a huge help to me as her mum, as that is a particularly stressful experience no matter how many times you do it.

To illustrate the importance of Beth in Charlotte's life, I would like to relay a conversation from earlier this week. I told Charlotte that by the time she went to school, she wouldn't have cancer anymore. She said, "Oh, but I like having cancer, Mama." I replied, "Why, Charlotte?" and she said, "Because I go to the hospital and I can play with Beth!"

When I relayed this to Beth, she quietly sat aside Charlotte and reassured her that she didn't need to have cancer to be her friend.... that she would always be there.

This was a truly genuine moment and really does display Beth's level of care.

So, thank you for making necessary medical intervention's more about music, laughter and friendship than about an austere clinical environment. The medical care has been amazing too, but Charlotte has come through this as a happy child through the efforts of the hospital staff to provide a family-friendly and supportive environment.

Thanks again,

Sincerely,

Sue & Maxim Burglauff
(The Burglauff family)
October 3rd, 2005

Dr. Catherine Crock  
Paediatric Haematology/Oncology Department  
Laboratory Services  
The Royal Children's Hospital  
Flemington Road, Melbourne  
Parkville, Victoria  
3052 Australia

Dear Cathy,

It is with great pleasure that I write to you to comment on my visit to The Royal Children's Hospital (RCH) in July 2005. My main academic interest is in the field of Paediatric Haemostasis, and I was originally scheduled to spend time with the team lead by Professor Paul Monagle during an observership in that area. However, during my visit I also had the opportunity to see the work that you have developed in the last six years in the Paediatric Haematology/Oncology Department regarding paediatric cancer patients.

I was very impressed by your program's quality and its advanced approach to paediatric cancer patients that are submitted to invasive procedures during their therapy. It was easy to realize that every small detail in regards to the procedures was well planned. At the family's arrival to the procedure area, parents are provided with personal pagers that allow them to move with freedom before they are called, decreasing the level of anxiety in the waiting room. In the procedure room, the children are able to participate by choosing their preferable “flavor” of the inhalatory general anesthetic agent to be used. This idea of participation provides them with a sense of security, by empowering them to influence the physician’s decision. The program also has instituted an exemplary musical therapy to distract and relax the patients while undergoing their procedures.
In summary, this comprehensive new approach allows each child and their parents to feel safer and in a friendlier environment. Most importantly, the program has modified the patient’s perceptions regarding their procedures allowing them to cope better with their underlying medical condition.

For those reasons, I am asking your permission to liaise our local musical therapist, Ms. Ruth Roberts, with your program. I hope this letter will allow both programs to exchange ideas within this area that may revert in other benefits to this patient population.

I am delighted to write this letter of support to your program. Please, do not hesitate to contact me if I can be of any further assistance.

Yours sincerely,

Leonardo R. Brandão, MD
Haemostasis/Thrombosis Program
Division of Haematology/Oncology

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Results of Royal Children's Hospital Parent Pager Evaluation – Parents / Others undertaken May / June 2007

**Purpose**
This brief audit was undertaken to establish a baseline of the level of use and satisfaction with the Parent Pagers within the Day Procedure and Day Oncology units. Following this initial survey the questions will be reviewed and revised to enable further relevant evaluation to take place. The plan is to undertake ongoing audit with collation of results on a monthly basis.

The survey is divided into three key areas:
- Is the Parent familiar with the pager system?
  - If no, would they consider using the pagers?
  - If yes, what are their thoughts on the pagers?

**Results**
A total of 18 parents were surveyed. The age of the patients ranged from 22 months – 14 years.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Outcome</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of survey</td>
<td>Day procedure unit = 6 (33%) Day Oncology unit = 12 (67%)</td>
<td></td>
</tr>
<tr>
<td>Relationship to patient</td>
<td>Parent = 18</td>
<td></td>
</tr>
<tr>
<td>Are you familiar with the Parent Pagers?</td>
<td>Yes = 17 (94%) No = 1 (6%)</td>
<td>1 respondent removed from survey</td>
</tr>
<tr>
<td>When were you informed about the pagers?</td>
<td>On admission = 15 (88%) Don't remember = 1 (6%) Not informed = 1 (6%)</td>
<td></td>
</tr>
<tr>
<td>Who informed you about the pagers?</td>
<td>Admitting nurse = 16 (94%) Other parents = 1 (6%)</td>
<td></td>
</tr>
<tr>
<td>Have you used the parent pager yet?</td>
<td>Yes = 11 (65%) No = 6 (35%)</td>
<td></td>
</tr>
<tr>
<td>If no, do you think you will use it at some point?</td>
<td>Yes = 6 (35%)</td>
<td>- great idea – would like to use - great as daughter is teenager and unit can be noisy - more freedom to leave the unit</td>
</tr>
<tr>
<td>Respondents remaining = 11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you given verbal / written instructions on pager?</td>
<td>Yes = 6 (all verbal) (55%) No = 5 (45%)</td>
<td>- written instructions would be useful</td>
</tr>
<tr>
<td>How useful did you find the pager?</td>
<td>Very useful = 8 (73%) Useful = 3 (27%)</td>
<td></td>
</tr>
<tr>
<td>How easy did you find the pager to use?</td>
<td>Very easy = 6 (55%) Easy = 5 (45%)</td>
<td></td>
</tr>
<tr>
<td>Average waiting time for appointments</td>
<td>40 minutes – 2 hours</td>
<td></td>
</tr>
<tr>
<td>Most common reason for leaving the unit?</td>
<td>Meal / coffee break = 11 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

**Comments**
- Great idea; very easy to use
• Very simple idea
• Very simple but concerned about battery life
• Possibly prefer to use mobile phone though pager is good
• Means we don’t have to wait in the unit
• Instructions would be useful re how far can we go from the unit
• Very easy – good idea
• Very simple idea – better than mobile as some black spots around the hospital
• Child likes to wear the pager and take ownership of it!
• Need to ensure the alarm is on the highest setting so it can be heard
• Gives us the freedom to move around
• Needs instructions attached

Day Procedure Unit

Parent Pager
Hush CD and Day Procedure Unit Staff
Submissions Clinical Excellence and Patient Safety

“Are the Kids OK?” - A Child Protection Model of Care for the Royal Brisbane and Women’s Hospital Health Service District
Royal Brisbane and Women’s Health Service District (RBWH HSD), Department of Social Work Services, Herston, QLD

Author(s)
Helen Redfern Project Manager, RBWH Child Protection Model of Care Project
Research Coordinator, Department of Social Work Services, RBWH
Heather Lord Project Officer, RBWH Child Protection Model of Care Project
Janis Hinson Child Protection Advisor (RBWH HSD); Learning and Development Coordinator, Department of Social Work Services, RBWH

Abstract
In 2004 the Queensland Crime and Misconduct Commission completed an inquiry into child protection and the abuse of children in foster care. The outcome of this emphasised the need for a whole of government response to the protection of children and young people from harm or risk of harm. Subsequently, legislative changes required Queensland Health to assume an increased role in the prevention, identification of, and the response to, child protection. This resulted in the establishment of Child Protection Advisor roles and Child Protection Liaison Officers roles in each health district. The RBWH HSD Child Protection Model of Care Project was a 6 month project initiated in December, 2005 in response to these changes that reflected a contemporary approach to child protection. Key project findings were the need for specialised child protection training for an adult health context so as to create a child aware campus and a coordinated organisational response through a specialised child protection service which encompasses a statutory reporting response and a psychosocial response across a low to high risk continuum.

Introduction
The aim of the project was to develop a contemporary and sustainable model of care in child protection for the RBWH HSD based on best practice and the best available evidence.

Method
A proactive evaluation approach was undertaken and involved:
- a thematic analysis of 85 consultations (focus groups and individual) with stakeholders both internal and external to the RBWH District
- a literature review to ascertain the best research evidence
- a comparative analysis of child protection responses with other adult health care services locally and interstate.

Project conclusions
The project concluded in June 2006 with the following recommendations:
1. A new District response to child protection was required to build organisational capacity to respond to ongoing child protection requirements.
2. A new model of care for child protection is implemented that reflects contemporary and evidenced based practice that fulfils the criteria below:
   - we can evidence that we are a child aware campus in an adult health setting
   - we have a trained and supported workforce capable of fulfilling their reporting responsibilities and accountabilities for child safety.
3. We provide appropriate and timely clinical responses with respect to identification, assessment, intervention, referral and collaboration with other key players in the child protection system.

4. No child or family suffers harm from our lack of identification, reporting and follow up.

Application of EQuIP Principles

Customer focus
- provides an ongoing understanding of the needs and expectations of present and potential consumers highlighting the needs and rights of the “invisible child” in an adult health setting
- creating a child aware campus at all levels of the organisation to ensure effective, timely and appropriate intervention
- the model of care provides collaboration and partnerships with key stakeholders including other Health Service Districts and key child protection agencies. This is across key risk areas such as mental health, substance misuse and domestic violence.

Effective leadership
The RBWH Executive Group have endorsed the model of care in principle and have provided recurrent and increased funding for the two key child protection roles in the District. The location and clinical governance of the Child Protection Service is currently under determination.

Continuous improvement
Identified organisational benefits of the new model of care are:
- an increased capacity for the RBWH to provide child protection expertise specifically in the early identification of, and intervention in, child protection matters through the establishment of a Child Protection Service
- reduced risk of sentinel and critical incidents in child protection through improved communication, trained and supported staff and improved organisational processes.

Outcomes
The new model of care incorporates the critical elements of best practice in accordance with consultation and research and includes a multifaceted structured response to child protection that builds organisational capacity outlining the response at the organisational, workforce, specialised service and collaborative levels.

Striving for best practice
This model of care for child protection has been based upon the best evidence from contemporary child protection research literature, current policy initiatives and from wide consultation including other major Australian tertiary health facilities.

Innovation
Project findings identified that there was no current best practice model for an adult health setting placing this at the cusp of innovation.

Applicability to Other Settings
This model has been developed for adaptation to other tertiary level health care settings.
A Question of Safety, Hydro, Hypos and Heat
WACHS – Great Southern Community Health, Population Health, Albany, WA

Author(s)
Christine Hunter  Senior Community Physiotherapist
Marcelle Cannon  Program Co-ordinator Community Health

Other contributors to project:
Shirley Cornelius  Clinical Nurse Specialist
Lindsay Henson  Allied Health Co-ordinator
Jenny Hood  previous employee WACHS

Aim
To prevent, (where possible), further clinical incidents of hypoglycaemia and to develop a protocol to enhance the safety of People with Diabetes on hypoglycaemic agents during hydrotherapy.

Abstract
The occurrence of a clinical incident (hypoglycaemic episode) and the subsequent investigation revealed:

- A need for improved information on the impact of hydrotherapy on blood glucose levels.
- A need for improved systems and processes to reduce the likelihood of further clinical incidents.

The team undertook extensive literature searches and conducted mini-research projects to develop clinical information on this area and to develop appropriate policy, procedure and practices to reduce risk and improve client outcomes.

Outcomes
- Increased knowledge and awareness (about preventing/managing hypoglycaemic episodes) of staff supervising hydrotherapy sessions.
- Development of new knowledge regarding the importance of gathering diabetes related information during assessment of patients attending hydrotherapy sessions.
- Endorsement and use of client protocol for all people with diabetes attending hydrotherapy.
- Information sheet developed for people attending hydrotherapy.
- Increased awareness by clients of possible fluctuations in their Blood Glucose levels.
- Implementation of procedure on the management of hypoglycaemia in relation to hydrotherapy.

Application of EQuIP Principles
The diabetes team’s work in this area has embodied the EQuIP Principles in the following ways:

Consumer focus
The team’s commitment to trying to prevent adverse outcomes for consumers has been the driving force behind all the strategies that have been implemented. The team has not been satisfied with addressing only the instigating incident but looking broader to see if other consumers in other contexts may be at risk (e.g. land based groups).

Effective leadership
The diabetes team has shown great leadership in setting up safety systems that can be easily
monitored and that are backed up by strong methodology. This has been inspiring to the local team but also health care professionals from across the country.

**Continuous improvement**
The fact that this work has been ongoing since 2004 and the monitoring and improvement is still occurring is evidence that the staff see continuous improvement as an embedded part of their day to day practise.

**Outcomes**
The team has measured both qualitative and quantitative outcomes in this area of their practise and have used these to improve and modify their procedures and resources all to the benefit of consumers.

**Striving for best practice**
The team has been proactive in publishing their work and seeking feedback from other professionals and health services to see if they can make further improvements. They are also investing time in taking the research side of the program further to add to the body of literature on this issue.

**Innovation**
As shown by emails from all over Australia, there is no evidence or guidelines available to help develop protocols and procedures with regards to the management of People with Diabetes on hypoglycaemic agents taking part in physical activity in hydrotherapy pools. The sharing of information between health professionals across the country has shown that this is a previously uncharted topic of clinical investigation.

**Applicability to Other Settings**
- The clinical knowledge, protocols and patient resources are able to be used by any service providing hydrotherapy to people with diabetes on hypoglycaemic agents.
- The same knowledge, protocols and resources can also be modified for land based programs for people with diabetes on hypoglycaemic agents.
An Innovative and Relevant Aggression Management Program  
Lottie Stewart Hospital, Dundas, NSW

Author(s)  
Michelle Hucker, Risk Coordinator  
Barbara Scales, Deputy Director of Nursing

Aim  
To apply risk management principles to staff aggression accidents, utilising the accident reports and local knowledge, to minimise risk to staff and improve clinical practice in behaviour management.

Abstract  
Aggression accidents from patients towards staff are a high frequency occurrence. Local analysis of the aggression accidents results in more relevant education and clinical practice. Staff aggression accidents were systematically analysed in terms of:

- Number of accidents.  
- Designation of staff injured.  
- Clinical area staff was working in.  
- Did that resident have a history of aggression.  
- Was there anything that could have been done to prevent that accident. Later, the time of the accident was added to the analysis to provide a more comprehensive evaluation.

Application of EQuIP Principles

Customer focus  
The effective management of patient aggression will reduce patient aggression. (prevent escalation, and reinforcement of behaviours where the patient is angry or distressed)

Effective leadership  
This unique program was initiated by Lottie Stewart Hospital on the basis of local needs. It has been effectively maintained over a 5-year period thus far, and drives the aggression management education for both managers and staff.

Continuous improvement  
- This ongoing program ensures that the management of behaviour and aggression at Lottie Stewart Hospital is maintained.  
- This is evidenced by the percentage of preventable aggression accidents decreasing, then stabilising over time.

Outcomes  
- A very tailored aggression management program.  
- Training based on evidence.  
- Staff satisfaction with the program.  
- Improved reporting rate.  
- Improved the safety culture around aggression, so that staff are more likely to report accidents and be supported by management.  
- To improve reporting rates, and create a realistic picture of the aggression problem.  
- To provide all Nurse Unit Managers with the tools to provide the best timely advice to staff when a new resident is admitted or a resident becomes aggressive.  
- Time frames that injuries are occurring are known.
• Triggers of resident aggression at Lottie Stewart Hospital are known.
• Preventative action which may have helped is identified.
• Trends are identified.

Striving for best practice
• Research and reports are included in Managers Education.
• This innovative aggression management program, is unique.

Innovation
This is a unique program utilising available data and expertise. The only cost is time.

Applicability to Other Settings
• This program could easily adapted by other facilities, with the willpower to improve aggression management.
• It is equally applicable to hospital and community settings.
• It is best suited to small or medium sized settings (or wards) with a high aggression incident rate.
Acute-Post Acute Care (APAC) / General Practitioners Shared Care
Northern Sydney Central Coast Health Service

Author(s):
Nicholas Marlow  Area Manager, Acute-Post Acute Care
Jairo Herrera

Aim
To fill the gap between acute hospital and community care and to provide general practitioners with access to acute / post acute care patients preferring treatment at home.

Abstract
Traditionally access to APAC was only through the acute inpatient setting. General practitioners (GPs) often indicated that they prefer to initiate referral and retain responsibility throughout their patient’s illness regardless of the venue. The opportunity to manage more acutely ill patients increases job satisfaction and may attract new doctors to under-resourced areas. Patients prefer to be treated at home or in a Residential Aged Care Facilities (RACF) rather than travelling by ambulance, waiting in Emergency Departments and subsequently being admitted to hospital when they can achieve the same clinical outcomes.

Application of EQuIP Principles

Customer focus
Patients prefer to be treated at home or in a Residential Aged Care Facilities (RACF) rather than travelling by ambulance, waiting in Emergency Departments and subsequently being admitted to hospital when they can achieve the same clinical outcomes.

Effective leadership
The APAC model was considered too hospital-centric and undervalued the important role of GP’s. Recognising this concern, discussions were held with Divisions of General Practice regarding a new entry point that would allow GP’s to refer directly to APAC without involving the hospital. A decision was made between APAC and the Central Coast first and more recently, the Manly Warringah Division of General Practice to establish the APAC/GP Shared Care program.

Continuous improvement
An independent evaluation of the program was undertaken to review the clinical governance, safety of patient care and the cost effectiveness and sustainability of the Program.
Outcomes
To date the two programs have avoided 85 hospital presentations without any clinical adverse events and have registered the following service providers:
The APAC/ GP Shared Care Program has enabled people using public health services to experience an option of care that underpin the primary health care principles to meet each individual's needs by incorporating a high quality, appropriate, safe care option. The redesign of the APAC service to include a GP direct referral optimises the patient journey and experience reflecting a better access to care.

Striving for best practice
- Legal advice regarding vicarious liability was sought independently by both Area Health Service, GPs and supported by the Steering Committee.
- All clinical guidelines were developed in consultation with GPs and ratified by the Central Coast, Northern Beaches Drug & Program Steering Committees
- Registered program members and APAC staff were orientated to the program’s policies and procedures which incorporate clinical competencies.
- A risk assessment is documented on each patient admitted to APAC.
- Operational Flow charts have been developed to manage patient safety. This includes complaints, comments and media.

Innovation
GPs and specialist groups have demonstrated ownership of the Program by leading the orientation sessions and developing clinical guidelines which have enabled GPs to gain continuing professional development points.

Applicability to Other Settings
- Acknowledgement of the concept and results so far has been demonstrated by the endorsement by the CEOs to introduce this model of care across the remaining two Divisions of General Practice in the NSCCH.
- NSW Health has shown enthusiasm for the model of care by encouraging the Program and its dissemination across NSW by requesting this model of care to be published.
Adult Health Program Review
Sunshine coast health service district

Author
Kim Crisp, Team Leader, Short Term Care Team

Aim
To review the structure and model of service delivery of the Adult Health Program to enhance efficiencies and effectiveness and to ensure consistent service delivery across the District which was in line with funding requirements and strategic direction for the SCHSD.

Abstract
The Sunshine Coast Health Service District (SCHSD) received funding as part of the Queensland roll-out of the Pathways Home initiative aimed at supporting the transition from hospital to home of clients aged 65 years and over in the target areas dementia, falls prevention, cardiac and respiratory conditions. It was decided to take the opportunity to review the structure and model of service delivery within the entire Adult Health Program instead of just establishing a potential silo of service delivery within the program. Two project officers were appointed in September 2005 to oversee the review. The aim of the Adult Health Review component of the project was to identify:

- the scope of current service provision
- internal and external issues impacting on service delivery
- linkages with other services
- how Pathways Home and Chronic Disease funding may impact/complement existing services.

A comprehensive plan of consultation, change management, collation and collaboration using innovative strategies was developed. Three options for models of service delivery were developed based on current best practice. Each model was evaluated against set criteria including ability to address EQuiP standards, and the model of best fit was determined and subsequently implemented. The Adult Health Program is now at the stage of ongoing monitoring and formal evaluation of this restructure. The new model of care is also providing opportunity for service development and new initiatives, new funding opportunities and formal performance monitoring and evaluation of service delivery.

Application of Equip Principles

Customer Focus
- the client journey through the health system is the key focus.
- Aim was to create a system that was easy to access and navigate
- Continuity of care and smooth, seamless transition from one phase of service provision to another.
- Integrated Service delivery across the continuum are key issues addressed in recommendations relating to referral pathways, case conferencing, documentation, information systems, intake processes etc.
- Consumer feedback will be component of the evaluation process
- Consumer needs identified through QHealth focus groups were built into initial data collection and identification of issues.
- Model is built around Primary Health Care and Self Management principles.

Effective Leadership
- The development of Team Leader positions in addition to the existing Program Manager role will enhance the management and support framework for the service and staff.
CLINICAL EXCELLENCE AND PATIENT SAFETY

- Creation of a coordinated leadership team to support service delivery and staff
- Enhanced professional support and supervision for staff members
- Identified role delineation between Program Manager and Team Leaders around key areas of operational issues, staff support, cost centre management, service development and evaluation, performance monitoring etc

Continuous Improvement
- The revised structure will provide a platform for monitoring, review, data collection and analysis and quality improvement.
- Ongoing monitoring and evaluation of the review is built into the project, including a review by an external reviewer after 12 months and will include consumer feedback.
- Team Leaders will assist the Program Manager guide the team through such activities.
- Team Leaders will all share discipline groups and specific service areas within the Program to focus on continuous quality improvement.

Outcomes
- Outcomes and the attainment of specific objectives of the program will be reviewed by an external reviewer.
- Each team and discipline group have identified performance indicators to monitor and evaluate areas of service provision including waiting times.

Striving For Best Practice
- Review service delivery in key clinical areas including cardiac, respiratory and falls prevention in line with evidence-based practice and best practice.
- The structure for the Program was developed around a review of current best practice in line with local needs.

Innovation and Applicability to Other Settings
The Adult Health Program, Sunshine Coast Health Service District has shown itself to be an innovative leader in the current climate of review of Community Health Services across Queensland Health State. Learnings and recommendations can be fed into the State-wide process. As recommendations and strategic direction was based around QHealth strategies and discussion papers and project officers worked in collaboration with projects in other areas eg The North Lakes Project, direction reflects current trends and focus at a State level and current best practice.
Changing to Chairs- Models of Care in the Day Surgery Unit
North Coast Area Health Service, Ballina Hospital, Peri Operative Service, Day Surgery Unit, Ballina, NSW

Author
Emma Smith  Nurse Manager

Aim
The aim of the alternative Model of Care in the Day Surgery Unit was to enhance the patient’s journey through supporting timely post operative recovery and early discharge

Abstract
This paper highlights how a change in the Model of Care in second stage recovery, has led to a reduced average length of stay for peri operative patients. A randomized study was conducted to evaluate the effects of patient recovery time when recovered in a recliner chair as opposed to the more traditional method of a hospital bed. The results showed that those patients recovered in a recliner chair were discharged on average 36 minutes faster than those recovered in a bed.

Application of EQuIP Principles

Customer focused
- Patient care has been enhanced by separating the pre and post operative patients, whilst providing an ambient environment for our patients.
- Consumer input was obtained, and enhancements to the environment were made. Simple changes were implemented, such as plants, artwork, relaxing music, magazines and puzzles. There is also a health promotion board that focuses on the NSW Health topic of the month.

Effective leadership
- Extensive consultations were required to alleviate staff concerns and validate the model of care proposed.
- Local guidelines were established and a system implemented where the nurses documented every time they had a clinical indication to use a bed.
- Staff were also encouraged to document each shift the positive and negative aspects of the model of care.

Continuous improvement
- Altering the model of care and reducing the length of stay in the DSU has an impact on several levels within our organisation. Firstly patient care has been enhanced by separating the pre and post operative patients, whilst providing an ambient environment for our patients.
- Secondly by reducing the LOS, there are efficiency and potential cost benefits by reducing the need for overtime and maximising throughput.

Outcomes
- **18% or 36 minutes** decrease had been achieved by introducing the alternative model of using chairs.
- The ALOS post operatively in the DSU in 2006 was 144.72 compared to 176.62 minutes in 2005.

Striving for best practice
- In addition to local procedures, a team commitment has been essential in maintaining this model of care.
A patient satisfaction survey will be completed in the near future that will allow the team to gain valuable data in respect to the experiences of patients that have been recovered on both a recliner chair and hospital bed. Anecdotal evidence suggests that pain and nauseas levels may be less for those patients that recover in second stage recovery on a recliner chair.

Innovation

- Part of the DSU was required to be used for the general in patient use during three months of renovation work from October 2006.
- The DSU had effectively lost 50% of its existing space and creative planning was required to maintain services and sustain throughput to avoid delays to the surgical waitlist.

Applicability to Other Settings

Benchmarking within NSW Health identified that a number of peri operative services have the potential to implement this model of care. Creating better experiences for people using the health service has positive gains for the staff, health service and most importantly the patient.
Clinical Observational Audit on Breast Cancer and NHL
National Capital Private Hospital, Nursing, Garran, ACT

Author
Kim McGovern     Nurse Unit Manager

Aim
To estimate the relative dose intensity (RDI) of chemotherapy given to patients in clinical practice for the treatment of early stage breast cancer (ESBC) and for intermediate / high grade non-Hodgkin lymphoma (NHL).

Abstract
Maintaining chemotherapy dose and schedule is imperative for achieving optimal treatment outcomes. A positive relation between dose intensity and response rates has been shown in many common cancers including breast cancer and lymphoma. Neutropenia is the major dose limiting toxicity of chemotherapy and the primary driver of dose delays and dose reductions that result in a low relative dose intensity.

The premise is that many Australian patients currently receive less than 85% of their RDI planned chemotherapy treatment.

The purpose of this observational clinical audit is to assess chemotherapy regimen, chemotherapy dose delay and dose reduction, chemotherapy dose delay and dose reduction specific to myelosuppression, growth factor usage, febrile neutropenia and hospitalisations specific to febrile neutropenia.

Application of EQuIP Principles

Customer focus
- Patients >85% of their RDI chemotherapy on schedule.
- Increased patient remission.
- Decreased disease progression / relapse.
- Increased quality of life related to no/low hospitalisations.

Leadership
- A working party was formed.
- NUM is committed to the patients receiving optimal chemotherapy doses to improve chances of remission.
- NCPH is committed to ensuring ‘best practice’ be delivered.

Continuous improvement
- Data collection will provide evidence that patients receive their RDI of chemotherapy on time for the intended course.
- By decreasing the chance of febrile neutropenia and subsequent hospitalisations ensures patient quality of care.
- Patients who receive chemotherapy on time at appropriate dosing will improve their chances of remission.
Outcomes (audit still in progress)
Patients requiring growth factors to support and maintain optimal chemotherapy doses on time will result in no or limited hospitalisations, better quality of life whilst receiving chemotherapy and the best chance of remission and ultimately cure.

Striving for best practice
- Data collected will be benchmarked against other institutions in the use of growth factors for administration of chemotherapy to patients with breast cancer and non-Hodgkin’s lymphoma.
- Intention is to present nationally and encourage other institutions who may not be giving their patients the best chance or remission / cure.

Innovation
- Data collection will provide planned chemotherapy doses, actual doses, the administration of growth factors and any unplanned hospitalisations related to febrile neutropenia.
- Data will then benchmarked across Australia, which has not previously been done.

Applicability to Other Settings
The collection of data could be easily be used for any oncology outpatient setting.
Development and Evaluation of a Formal Curriculum in Patient Safety for Final Year Medical Students
Southern Health, Quality Unit, Clayton South, VIC

Author(s)
Brendan Flanagan  Director
Julia Harrison  Course Coordinator
Stuart Marshall  Instructor and Researcher
Nicholas Chrimes  Instructor
Anna Korin  Instructor
Darren Teoh  Instructor
Helen Kolawole  Instructor
Jennifer Hogan  Simulation Coordinator
Tracey Nichols  Simulation Coordinator
Susan Ballinger-Doran  Simulation Coordinator

Aim
To improve patient care by providing final-year medical students with the knowledge, skills, behaviours and attitudes to better prepare them to function as safe practitioners in the complex healthcare environment.

Abstract
A new subject for final year medical students at Monash University began in 2006. The idea for the simulation centre course had its origins in late 2004 when Dr Brendan Flanagan (subject leader), Associate Professor Michael Buist, and Dr Julia Harrison (subject coordinator) approached Monash University about establishing a Patient Safety Education Unit within the Faculty. The subject, which runs over five days, aims to provide students with knowledge, skills, professional behaviours and attitudes that promote patient safety. Each day includes a combination of lectures, workshops and simulation scenarios, using state-of-the-art computerised mannequin simulation technology at Southern Health’s Simulation and Skills Centre.

The scenarios enable the students to practice the management of challenging clinical situations in real-time in a safe learning environment as well as practice aspects of teamwork and communication. The contact days are weaved throughout students’ clinical placements and are designed to complement clinical activities.

Students are assessed in structured clinical examinations on the final day as well as through contributions to an online discussion linking the learning environment to the clinical setting. This is the first attempt at comprehensive integration of patient safety themes into an undergraduate medical curriculum in Australia, and to our knowledge the most comprehensive undergraduate course in patient safety in the world.

Students were surveyed to evaluate the new subject, and overall attitudes to safe practice were judged using a specifically designed survey about patient safety. The attitude survey has been assessed for statistical reliability and has face validity for safety in the broader healthcare environment.

The subject was undertaken by 175 students in 2006. Most reported non-technical skills such as teamwork and human factors as the most valuable lessons learnt. Change in practice was identified in areas such as improved communication and awareness of error (40%). More than 75% of students felt the course increased their confidence and competence in the clinical setting and led to increased learning in the clinical environment.
The data collected demonstrated a deeper appreciation of the students for patient safety. The positive multimodal evaluation of this course is being followed by targeted examination of specific areas of course content by a series of prospective trials.

Application of EQuIP Principles

Customer focus
The overriding theme of the subject is ‘patient-centred care’.

Effective leadership
The course is the first of its kind in Australia.

Continuous improvement
The course has undergone refinement based on comprehensive student feedback at the end of 2006.

Striving for best practice
The course was developed based on a best-evidence approach to patient safety practices based on resources from around the world.

Innovation
- The subject won the Dean’s award for Teaching Excellence in the Innovation category, in the Faculty of Medicine, Nursing and Health Sciences at Monash University in 2006.
- The course has attracted interest from the World Health Organisation and the Chief Medical Officer in the UK regarding innovation in teaching patient safety.
- The use of a simulation-based blended learning method is novel.

Applicability to Other Settings
This course could be extended both:
- horizontally into other undergraduate programs such as nursing and allied health (discussions are underway), and
- vertically, both earlier in the curriculum, as well as incorporation into postgraduate curricula. Some of the course material has already been developed into learning packages for use in postgraduate training in hospitals, in conjunction with the Postgraduate Medical Council of Victoria.

This style of training could radically improve awareness of risk and safety in health care for all professional groups and provide strategies to minimise these risks.
Development of a Physiotherapy Outcome Measure for Palliative Care Patients – it’s a GAS!
Calvary Health Care Sydney, Palliative Care Physiotherapy, Kogarah, NSW

Author(s)
Roslyn Savage  Senior Palliative Care Physiotherapist
Jill Gibbons  Senior Palliative Care Physiotherapist
Kathy Potter  Palliative Care Physiotherapist

Aim
The goal of this project was to implement a functional outcome measure for patients attending a palliative care gym program.

Abstract
Loss of mobility and functional independence are closely related to a decline in quality of life for palliative care patients. A Gym Program was developed in 2002 for palliative care patients of Calvary Health Care Sydney with the aim of maximizing function and facilitating the discharge process. Anecdotally, physiotherapists have assisted patients in improving strength and mobility in preparation for their return home, however there is limited evidence supporting this.

A Patient Satisfaction Survey in 2003 showed that subjectively the gym program led to an improvement in the patients’ strength, function and quality of life. However there was no objective measure to assess the effectiveness of the therapists’ intervention in the gym program.

Following discussion with our Research Coordinator, palliative care physiotherapists in other facilities and a literature review, Goal Attainment Scaling was identified as a potential outcome measure. It was trialled in the Gym Program for a 3-month period in 2005. The results for the first 30 patients were evaluated and showed 93% of patients achieved an increase from their baseline function, 78% of patients whose goal on admission was to return home succeeded and 64% of patients discharged home achieved their predicted outcome.

Goal Attainment Scaling measures goals pertinent to individuals rather than a general scale. It is valid even when patients have different goals as it allows comparison of patients’ relative success in achieving their unique set of goals. It is responsive to small but clinically important changes in performance. It is now routinely used in the Gym Program as an outcome measure.

Application of EQuIP Principles

Customer focus
• Use of Patient Satisfaction Survey to gather information about the program. This survey is currently being repeated.
• Goal Attainment Scaling is an outcome measure that allows patients to identify their individual goals of treatment. Involving the patient in this process ensures they are the priority and director of their treatment program.
• Objective data from the Gym Program can now be presented within the context of the multidisciplinary team.

Effective leadership
The success of this project was due in part to the determination of the physiotherapists in searching for an appropriate outcome measure in palliative care. Management within the physiotherapy and palliative care departments supported this long-term approach. The Quality Manager promotes a culture of providing best practice clinical care within the CHCS workforce.
Continuous improvement
This has been a lengthy quality improvement project that began when access to a gym space became available in 2002. The process continues with the commencement in 2007 of a study comparing Goal Attainment Scaling with two other functional outcome measures and repeating of the Gym Patient Satisfaction Survey.

Outcomes
- Goal Attainment Scaling has been implemented as an outcome measure for patients attending the palliative care Gym program.
- Physiotherapy staff report increased satisfaction with the ability to provide meaningful data that supports best practice.
- Gym attendance figures continue to increase.

Striving for best practice
- Presentation to peers in palliative care and aged care services.
- Presentation of results at the 8th National Palliative Care Conference in Sydney 2005.

Innovation
Development of a clinically relevant outcome measure

Applicability to Other Settings
- Can be utilized by other palliative care physiotherapists.
- Can be utilized by other teams involved in patient rehabilitation.
Development of a Visual Feedback Tool to Improve Fluid & Medication Compliance amongst Indigenous Clients in a Haemodialysis Satellite Unit in Remote Australia

Tennant Creek Hospital Dialysis Unit - TENNANT CREEK, NT

Author
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Jenny Cutter            Nurse Unit Manager, Casey Dialysis Unit, Berwick, Victoria

Aim
To improve patient Intra Dialytic Weight Gains and reduce high serum phosphate levels in the patient population.

Abstract
Consistently large Intra Dialytic Weight Gains in approximately 50% of patient population. Frequent use of Isolated Ultra Filtration to achieve patients' Ideal Body Weight.
High Serum Pre Dialysis Phosphate Levels. Caring for Australians with Renal Impairment guidelines, state the recommended pre dialysis serum phosphate level 0.80 -1.60.

Methodology
A visual tool was modified for our 100% indigenous population, providing patients with a chart illustrating their progress with fluid and phosphate levels in graph form.

Patients were requested to bring in their weekly medications (Webster Packs) for review, Intra Dialytic Weight Gains & serum phosphate levels were measured for a period of 3 months pre implementation, and 2.5 months post implementation of Visual Tool.

Outcomes
• 73% of the target population demonstrated a 12.5% reduction in Intra Dialytic Weight Gains.

• 53% of the target population demonstrated a reduction of 6% in serum phosphate levels.

Conclusion
• The reduction in Intra Dialytic Weight Gain can be attributed to the introduction of the visual feedback tool, which has provided patients and staff with an individual picture of their progress, and more specifically, a guide illustrating staff expectations of acceptable Intra Dialytic Weight Gain.

• The improvement in serum phosphate levels is promising, but cannot be attributed solely to the introduction of the visual tool, as dispensing and monitoring of Webster packs, which included patients phosphate binders, was introduced in conjunction with the tool.

Application of EQuIP Principles

Customer focus
• Dialysis patients were invited to participate in a Patient Satisfaction Survey in 2006.

• Evaluation of the survey data identified a lack of information offered to patients in relation to their blood results and little or no explanation about the medications dispensed.
Effective leadership

- The Clinical Nurse Specialist adopted a visual feedback tool based on a similar tool used at several dialysis units in the United Kingdom.
- A double-sided colour chart reflects the acceptable Intra Dialytic Weight Gain on one side and the reverse side shows the blood result trends for the year.
- The patients have responded positively to the visual method of delivery of information and comprehend the clinical intervention of dialysis treatment.

Continuous improvement

- Monthly patient and nursing staff meetings held to educate patients on the need to take medication with food on a regular basis.
- Weekly monitoring of the dispensing of medication packs (Webster packs)
- Patients requested to bring their Webster packs to each dialysis treatment.
- Patients encouraged to take phosphate binders with meals provided at dialysis treatment.
- Visual Feedback records discussed with patients.

Outcomes

- Following the introduction of the new medication regime and the implementation of the visual feedback tool, patients recorded an overall improvement in the phosphate and fluid control.

Striving for best practice

- The recording of patient information in the medical record in relation to this initiative is inclusive in the total patient care mapping undertaken by all nursing staff.
- Staff support of this initiative, together with strong customer focus promoted by the Dialysis Unit Manager will ensure the sustainability of this project.

Innovation

- At the time of the study all patients attending for dialysis were Indigenous Australians.
- Australian indigenous culture traditionally depends on oral and pictorial means of communication and expression.
- The Visual Feedback Tool was developed in response to an identified need to improve communications to patients in relation to their dialysis treatment and medication regime.

Applicability to Other Settings

- Child Health – weight and height recording for:
  - Consumers with poor literacy and numeracy skills
  - Consumers with English as a second language
Development of the Rapid Admission and Planning Unit
Royal Darwin Hospital, Division of Surgery, Casuarina, NT

Author(s)
Tracy Espie  Clinical Nurse Manager RAP
Dr Diane Howard  Director Medical Division
Sharon Sykes  Nursing Director Surgery

Aims
The initiative aims to enhance patient care delivery and promote clinical excellence through a patient focused, team approach to patient management.

Abstract
In response to the increased demand for services, Royal Darwin Hospital opened a nine bed Surgical Rapid Admission and Planning (RAPU) in August 2006. The unit is an area where suitable patients identified as needing admission to hospital undergo rapid assessment and initial treatment with the purpose of establishing an efficient and effective plan of care that minimises their hospital stay.

RAPU have additional Medical, Nursing, Allied Health and Discharge Planning support and fast track diagnostics to optimise the efficiency of patient flow through the unit. It concentrates the required resources and attention at the most vital and opportune time of a patient’s hospitalization. There are also community supports in the form of Hospital in the Home and Case Management of Chronic Disease patients that are developing with the unit.
This preliminary measure that will be extended to a 24 bed combined Medical and Surgical RAPU in a purpose built area scheduled for completion in August 2007.

Application of EQuIP Principles

Consumer focus
- Active management of patients by a multidisciplinary team.
- Discharge from the unit to a ward or the community is at the earliest opportunity.
- Discharge Care Coordinator, Medical staff and Allied Health staff dedicated to unit.
- Dedicated Aboriginal Liaison Officer and access to Aboriginal Interpreter service.
- Patient information pamphlet development.
- Patient satisfaction survey is included as a key performance indicator.
- Utilisation of Hospital in the Home program.
- Case manage patients with chronic disease.

Continuous Improvement / Outcomes
Performance to date has been measured through a number of key indicators.
- Decrease in Emergency Department Waiting Times:
The average wait for a surgical patient from presentation at the Emergency Department to admission to a ward has decreased from 17.98 hours prior to the RAPU development to 7.23 hours since commencement of the unit. This translates top a saving of 533 bed days in the first 7 months of operation of the nine bed unit.
- LOS for surgical patients
The average Length of Stay of surgical patients has decreased from 3.65 days prior to the RAPU development to 3.00 since commencement of the unit. There has been a particularly significant decrease in the patients with cellulitis, abscesses and appendicitis.
- Increased activity in the discharge lounge
There has been an increased utilisation of the Discharge Lounge from 5 to 7 patients per say since the RAPU commenced.

- **Access block in the Emergency Department**
  Access block in the Emergency Department decreased from 59% in February 2006 to 33% in its first month of RAPU operation and has continued on this downward trend.

- **Patient and staff satisfaction**
  Surveys of patients and staff on the unit indicate that it is well received by both these key stakeholder groups.

**Effective leadership**

- Strong support from Government and Hospital Executive.
- Governance Group in place.
- Policy and protocol development.
- Key performance indicators and ongoing monitoring in place.

**Striving for best practice**

- Positive impact on patient care, utilisations of resources and staff morale.
- Promotion of teamwork.
- Deliver optimal patient treatment and progress.
- Expedite Medical / Surgical and multidisciplinary care.
- Facilitate consultation between Medical and Surgical in the care of complex cases.
- Improve access to diagnostics.
- Decrease the hospitalisation of patients with chronic disease through case management.
- Enhance communication and care of patients across health sectors.
- Decrease access block in the Emergency Department and promote effective patient flow.
- Gain efficiency through the use of care pathways.

**Innovation**

The RAPU has changed the approach to patient care planning and management of patients requiring acute surgical admission to Royal Darwin Hospital. It has seen a significant change in culture, process and practice within the hospital.

**Applicability to Other Settings**

Each health care setting is different but the concept of the RAPU could be adapted to other health care settings. The concept is patient focused and effective.
Dual Source Computerised Tomography Scanner
Sydney Adventist Hospital - San Radiology, WAHROONGA, NSW

Author
Hilary Kuwahata  Project Manager, Business Development Unit

Aim
To provide a service that reduced the overall anxiety, distress and pain felt by patients and their family members due to lumbar punctures and bone marrow procedures.

Abstract
In response to the demand for computerised tomography imaging, such that the existing CT scanner was being used to capacity, and to maximise the opportunity to improve the imaging service provided by San Radiology, options for the purchase of a new CT scanner were investigated. The Hospital Board of Directors approved the purchase of the first Siemens Somatom Definition Dual Source scanner to be installed in Australia. Alterations were carried out to accommodate the scanner within the existing department, staff were recruited and trained in the use of the scanner and the interpretation of the images it produces, process changes were implemented to improve the CT service and the new scanner marketed to doctors to ensure that they were aware of the new technology now available to them. As a result San Radiology continues to provide leading edge multi-modality imaging services to our customers.

Application of EQuIP Principles

Outcomes
The installation of the second CT scanner has allowed San Radiology to provide a more efficient scanning service and to accommodate urgent requests in a timely manner. In particular, the dual source scanner enables more accurate, non-invasive investigation of:

- Symptom-free individuals at high risk of heart disease.
- Atypical chest pain.
- Status of coronary artery bypass grafts and disease progression after surgery or other intervention.
- In addition:
  - New scan modes increase the image quality in neuro-scanning and the ability to digitally subtract bone.
  - It provides the best power delivery currently available (160 kW due to the dual source generator design) which enables larger patients to be scanned with premium image quality.
  - The ability to conduct detailed imaging of cartilage, tendon and ligamentous structures, by isolating collagen and differentiation from soft tissue and fat.
  - Contrast agent concentration in the lung can be visualised without the use of an additional non-contrast scan.
  - Improved scanning of the liver, with the ability to create virtual non-contrast information without the need for an additional non-contrast scan.
  - Allows differentiation of calcified plaques from the contrast agent in large vessels. Allows visualisation of the chemical differences between, for example, uric acid and oxalate kidney stones.

Customer Focus
- Accommodates the increased demand for CT scans.
- Reduces waiting time for scans.
Cardiac scans are carried out without the need for beta-blockers to slow the heart rate, reducing risk to the patient.

The equipment accommodates larger patients than previous scanners.

Scans are acquired in a shorter time than with previous scanners, and with a lower radiation dose, yet images are of a superior quality.

**Effective leadership**

- Ongoing support from all levels of Hospital management
- Considerable financial commitment to the purchase of the scanner
- Significant contribution to all stages of the project by the Corporate Services Executive Officer, the San Radiology Manager and other senior staff members who led the various teams involved in the project.
- The San Radiology CT service is a worldwide reference site for Siemens. This is considered to be their premier cardiac site with radiographers travelling from interstate for pre-applications training.

**Continuous Improvement**

- The installation of the Dual Source CT Scanner provided the opportunity for San Radiology to provide an even more comprehensive imaging service to both inpatients and outpatients. The scans produced provide the highest level of diagnostic imaging currently available ensuring the most accurate diagnosis for patients and minimises the need for invasive procedures as a first line of investigation. Together with the services available from the hospital’s other diagnostic services, our patients can be assured of highly accurate diagnostic assessment.
- To ensure that quality care is being achieved and that the needs of patients and doctors are being met, San Radiology is carrying out surveys of patients scanned since installation of the new scanner and early replies indicate a highly positive response.
- A survey of doctors is currently being planned. The radiologists have engaged cardiologists so that CT now plays a greater role in their diagnosis. Patients are now being referred to San Radiology from major cardiac units both in Sydney and interstate.

**Striving for best practice**

Sydney Adventist Hospital has joined the ranks of elite medical institutions around the world with the installation of the first Dual Source Computer Tomography Scanner in Australia. Radiologists, cardiologists and other specialists have heralded it as revolutionising imaging of the heart and body and it will allow ‘one stop diagnosis’ across a range of conditions as it produces easily obtained clear images of internal anatomy and pathology and allows quick non-invasive diagnosis of potentially life threatening conditions.
Early Recognition of the Deteriorating Patient Project
ACT Health, Patient and Safety Quality Unit, Woden, ACT

Author(s)
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Imogen Mitchell  Director, Intensive Care, The Canberra Hospital

Aim
To implement a framework to ensure the early recognition of deteriorating patients, initiating an appropriate medical review and instigation of timely management.

Abstract
Patient adverse events in hospital are often triggered by the failure to recognise and appropriately manage deteriorating patients on the ward. This was identified as the lead clinical risk for ACT Health who subsequently sponsored a pilot project in 2006.

The “gold standard” for the early recognition of a deteriorating patient was described. Six major domains were identified as essential and were assessed during a 48 hour audit on the four pilot wards. Deviations from the gold standard were identified and subsequently, an intervention was developed to address the problem areas. The intervention included a comprehensive, interdisciplinary education package “COMPASS”, the introduction of the modified early warning scoring system, and the implementation of a new general observation chart.

The intervention was implemented into the four wards at the two hospitals over a four-month period. An audit performed during this period and a similar period the year before found that the documentation of respiratory rate had improved (35% to 97%), unplanned transfers to the intensive care unit had reduced (30 to 12), hospital mortality rate had reduced (2.4% to 1.1%), a decrease in the number of missed medical emergency team reviews (60 to 12) with a subsequent increase in emergency team reviews (51 to 63). The health professionals’ perceptions were that they had found the education package easy to follow and that it would change clinical practice. The ward intervention had been useful particularly with obtaining a medical review.

Application of EQuIP Principles

Outcomes
- Improvement in the documentation of respiratory rate (35% to 97%).
- A reduction in the number of unplanned transfers to the intensive care unit (30 to 12).
- A reduction in hospital mortality (2.4% to 1.1%).
- A reduction in the number of missed medical emergency team review (60 to 12).
- An increase in the number of medical emergency team reviews (51 to 63).
- A reduction in the number of complaints regarding patients' management (15 to 6).
- 124 participants found “COMPASS” easy to follow and it would change their practice.
- 98 ward staff found the intervention very useful and prompted earlier medical review.

Customer focus
- The initiative aimed to enhance patient safety by using a three tiered intervention to optimise the early recognition and management of the deteriorating patient.
- The intervention has the patient as the priority with both the education package focusing on patients and their illness, and the implementation of the modified early warning scoring system where the patient is the centre of care.
The consumer focus of the project was facilitated by the presence of an active and influential consumer representative on the steering committee for the project.

All major stakeholders in the intervention were represented in both the development of the intervention and the implementation of the intervention.

Effective leadership

- The ACT Minister for Health launched the project with positive media coverage.
- The CEO of ACT Health was the project sponsor. The Director of Clinical Governance at ACT Health attended all the steering committee meetings along with senior clinicians and nurses from the two hospitals.
- The senior clinicians led various initiatives developed.
- ACT Health’s Patient Safety and Quality Unit financially sponsored the project.
- The roll out of the intervention to the remainder of the wards has been agreed to and funded by ACT Health.

Continuous improvement

- The project has been successfully implemented into four wards and has been sustainable over four months with a view for it to be ongoing and rolled out to the remaining wards in the two hospitals.
- The sustainability is facilitated by observations being ubiquitous to all patient admissions to acute care hospitals and the education providing an understanding as to why and when observations take place.
- The sustainability of the project is encouraged by having a more realistic and practical release of staff given that only three hours is required for release and the interactive CD and online quiz allows flexibility for staff to undertake them where and when it is convenient for them.
- Outcomes were monitored and fed back to staff to encourage further participation in the pilot project.

Striving for best practice

- A literature review was performed to try and establish world best practice and benchmarking.
- The modified early warning scoring system has been seen as best practice in the United Kingdom and increasingly in Australia which was then adapted to suit the local needs.
- The education package has now been adopted by the Australian National University Medical School and University of Canberra Nursing School and has attracted keen interest from NSW Health.

Innovation

- The recognition and management of deteriorating patients up until recently has focused on rapid response teams, medical emergency teams and ICU outreach teams. Little is written in the literature with putting the responsibility back onto the wards supported by a comprehensive education package, a score to trigger a medical ward review and a new and novel observation chart.
- The education package is innovative and unique in that its premise is to provide basic physiological principles to underpin bedside care. The multidisciplinary approach and a multimedia construct encourage staff to learn and work harmoniously together, which should replicate a ward environment.
- The new colour coded observation chart with a clear layout for all vital signs is innovative and we have demonstrated that it does facilitate improvement in documentation and allow easy scoring of the modified early warning score.
Applicability to Other Settings

- As patients become older and sicker, deteriorating patients are likely to be a recurring feature of all acute hospitals. The failure to recognise and appropriately manage these patients is common throughout the world. This intervention is applicable to all acute hospital settings.
- The education package is also applicable at an undergraduate level and has been adopted into the fourth year medical program at the Australian National University and the third year nursing students at the University of Canberra.
eLearning: Providing a Flexible Environment for Ongoing Professional Development in the Healthcare Setting
Calvary Health Care ACT, Emergency Department, Jamison Centre, ACT

Author(s)
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Janet Watts  Clinical Nurse Manager (Emergency Department)

Aim
The aim of this improvement project was to find an effective, alternative solution to learning and development within the health care setting.

Abstract

Historically, effective and efficient continuing education for health care professionals has been difficult to achieve. Without an alternate approach, there exists the potential to diminish compliance with mandatory and continuing education standards and expectations.

Calvary Health Care ACT after identifying the above complexities associated with the provision of continuing education has developed and trialled an eLearning platform that provides a flexible modern mode of delivery for professional education.

Upon analysis of the information collected via subjective and objective methods, it was found that the major themes were focused around poor access to learning opportunities related to workload requirements, timing of training sessions and poor promotion of upcoming learning opportunities. The project team clarified and categorised the complexity issues associated with the provision of learning opportunities and a solution was proposed to establish an electronic training package, eLearning, which was simple, effective and available 24 hour a day.

Post completion of the education units/modules a local roll-out was attended and the participants where asked to complete a survey, rating their subjective response to the model and the model of online learning. While the sample group was quite limited, a 155% increase in the compliance to Medication Safety and Drug Calculations was seen.

The management team was supportive of the future of online learning as an alternative learning method to traditional methods currently used in the health care setting. The successful pilot program has led to the further development of modules.

Calvary Health Care ACT management/executive team have presented the eLearning modules to the Little Company of Mary (LCM) national executive education committee. This presentation has led to plans for the future implementation of a national LCM eLearning website. A national approach will aid in the sharing of best practise knowledge and continuity of care across all campuses.

Application of EQuIP Principles

*Consumer focus*
- eLearning provides the opportunity to credential staff in extended practise that would not normally be able to access education opportunities.
• Modules such as Nurse Initiated X-ray and Nurse Initiated Analgesia allow staff to credential in processes that streamline the flow of patients through the emergency department, thereby decreasing the overall length of stay.

**Effective leadership**

Education provided by the institution through the eLearning mode demonstrates leadership and insight into the needs of its staff with a vision of quality improvement.

**Continuous improvement**

• Since this implementation of electronic learning solutions at the Calvary facility regular auditing of information and access to the hosting intranet site occurs to establishing the ongoing effectiveness of the program.
• Since the release of online learning most hospital departments are working to create electronic learning modules relating to competency and learning needs within their own department. This is a clear demonstration of ongoing improvement and our commitment to learning a development.

**Outcomes**

• Subjective and objective feedback from the users of the eLearning modules/system have been collected and collated through a trial period.
• There has been a very positive effect on training targets.
• Staff have expressed a desire to continue this mode of education.

**Striving for best practise / Applicability to other settings**

• The ease of use of the software to create online learning modules has lead to ongoing creation of modules and a clear desire amongst hospital staff for further conversion of learning material into this format/mode.
• The popularity is ever increasing with negotiation occurring at management level to invite other hospitals under the Little Company of Mary banner to adopt the training methods.
• This process will provide a continuity of information and training methods amongst the Calvary sites leading to better communication and a single approach to learning delivery and information content.
Embedding an Evidence Based Treatment and Best Practice Service Model in Psychiatric Services
Ballarat Health Services, Psychiatric Services, Ballarat, VIC

Author(s)
Mr Michael Struth  Manager Ballarat Psychiatric Services
Mr Ken Burnett  Executive Director Psychiatric Services
Ms Tamara Irish  Manager Ballarat North Community Psychiatric Services

Aim
To develop a treatment system that genuinely considered the mental health needs of clients and their families provided by a potent, informed and confident workforce routinely assessing and delivering evidence-based & best practice treatments.

Abstract
In the beginning we asked ourselves “Is this a service that I would entrust a member of my own family to, confident they would receive the best treatment and care available?” The sad answer was “No”. The previous team functions of triage; crisis assessment and treatment; continuing care; and mobile intensive support and treatment were shown to inhibit capacity to consistently deliver optimal client services. These structures and processes created significant and avoidable disruption to continuity of care; limited the ability of staff to work across the continuum to provide effective evidence based bio-psycho-social treatment combinations or meaningful evaluation of client progress towards recovery.

We knew this because we reviewed the “lived experience” of clients. At any time a client, to the exclusion of their family, could see in one episode of care, up to twenty two (22) clinicians across five (5) treatment teams, with little idea of what the treatment plan would entail, their role and the role of their family.

The objective of the initiative was to implement an innovative model of care with targeted management processes that ensures clients and their families receive comprehensive, seamless treatment services through a more integrated service, delivered by a professional workforce clear in its ambitions and abilities, secure the very best outcomes for all. The achievements for our community are clear; more people access treatment earlier, emergencies are averted, and inpatient bed occupancy is reduced. Clients and families are involved and better satisfied, and there is a more motivated and healthier workforce at a reduced cost and professional pride abounds.

Application of EQuIP Principles

Customer focus
- the initial impact on current clients and clinical staff was a major consideration in the development and implementation of the project
- improved access for the community (clients, families, GPs, etc)
- improved responsiveness and timeliness of clinical services
- client and family health outcomes can vastly improve with routine provision of evidence-based treatments within existing budgets for routine public mental health services.

Effective leadership
- a discussion paper was developed and widely distributed internally and externally
- workforce re-training and professional development strategies.
**Continuous improvement**
Review of available data, internal clinical audits, Consumer and Carer Satisfaction Survey reports & Root Cause Analysis.

**Outcomes**
- an evaluation of the first twelve months has just occurred revealing a number of dramatic results against the key performance measures and benchmarked against the international literature
- improved safety and appropriateness
- equitable and manageable workloads
- reducing acute bed occupancy trends
- reducing re-establishment trends
- improved efficiencies (Reduced expenditure to the vicinity of $825,820 within the first ten months)
- reduction of Overtime hours
- transparency and accountability processes, continuous education and training contribute to improved workforce health, morale and job satisfaction.

**Striving for best practice**
- information was benchmarked against International literature, National and State Policy and ACHS EQUIP standards
- review of the Office of the Chief Psychiatrist clinical audit recommendations.

**Innovation**
- developing multi-disciplined clinicians to apply a full range of clinical knowledge using skills that better enable earlier and easier service entry for clients, and routine provision of effective treatment combinations for recovery
- significant clinical workforce change, including the re-organisation and integration of clinical teams
- reducing costly and intrusive acute psychiatric inpatient bed usage via responsive and more effective treatments for clients in their own environment.

**Applicability to Other Settings**
There is opportunity to significantly improve clinical workforce efficiencies increasing the capacity to serve the community, without increasing overall expenditure.
Emergency Department Case Coordinator
The Valley Private Hospital - Allied Health & Emergency Departments, MULGRAVE, Victoria

Author
Kerrie Walter              Allied Health Manager
Mandy Nichels           ED Case Coordinator
Mary-Jane Stolp         State Quality Manager

Aim
A Case Coordinator was appointed on a trial basis to improve continuity of care for consumers presenting to the Emergency Department (ED) with complex problems, as well as the appropriateness and effectiveness of care and services provided and access to support services ensuring safe, consumer focussed care is achieved.

Abstract
The purpose of the case coordination project has been to see if placing a clinician located at this pivotal gateway to the hospital would achieve
- A reduction in length of stay (and a reduction of consumers in step down)
- Better identification of consumers requiring complex discharge planning
- Earlier initiation of a discharge plan, including earlier referrals to allied health staff for consumers admitted to hospital.
- Improved liaison between the hospital and community services to achieve greater continuity of care at admission and discharge.
- Improved quality of care for consumers discharged from emergency as they are linked in with community services.

The exact nature of the problem was diagnosed through review of length of stay and readmission rates. Results of consumer satisfaction surveys and review of complaints received from ED consumers were also considered in determining areas needing improvement.

A review of the literature and discussion with peer organisations around Australia indicated the ED Case Coordinator model was the intervention most likely to be successful.

The cost of the project was the ED Case Coordinators salary for the 6 months of the project and this was easily offset by the savings created from the role.

The role of the ED Case Co-ordinator was to:
- Assess the consumer at the earliest possible moment to facilitate positive consumer outcomes and a well co-ordinated stay.
- Facilitate discharge planning and continuity of care through comprehensive assessment and reducing the pressure on other ED staff.

Application of EQuIP Principles

Customer focus
- Assessment, planning and delivery that is appropriate and effective and informed by the consumer’s involvement.
- 100% of consumers seen by the ED Case Coordinator indicated their satisfaction with the service provided
- Care is now more holistic and appropriate rather than diagnosis focussed.
• Improved access to community services
• Consumers and families are provided with long term plans to address their social needs on discharge from the ED, improving access to services, effectiveness of care delivery in the community and enhanced consumer safety.
• Emergency respite can be organized from the ED by the Case Coordinator for the presenting consumer or for their significant others where required
• Development of a brochure for consumers and families on ‘The Admission Procedure When Presenting To The ED’ to improve effectiveness and safety

**Effective leadership**
• Commitment shown from the Executive and Senior Management for facilitating positive consumer outcomes for ED consumers and a well coordinated stay.
• Education and training for all staff with regular feedback on project progress.
• 100% of consumers referred to the ED Case Coordinator were appropriate
• Establishment of a formal discharge planning committee across the two hospital sites to enhance the continuum of care by looking at streamlining admission and discharge planning for consumers.

**Continuous improvement**
• Updated policies and procedures
• Ongoing evaluation of consumer and staff satisfaction
• Ongoing review of complaints and adverse events to identify learnings and/or areas for improvement
• Improved safety for consumers evidenced by a reduction in adverse events

**Outcomes**
Data has been kept for the six months of the project on all consumers seen in ED to evaluate project progress in an ongoing manner and demonstrate project outcomes including: length of stay, representation rates, effectiveness of early allied health referrals on recovery and length of stay, complaints and incident data.

**Striving for best practice**
The ED Case Coordinator project has demonstrated striving for best practice through utilisation of information relating to the experience and success of case coordination projects in both private and public hospitals in Australia and overseas. Appointment of a person with extensive experience in ED Case Coordination responsible for setting up best practice projects in other organisations.

**Innovation**
This project is innovative because it demonstrates recognition by a private hospital of the need to operate as part of a continuum of care. Through this project we have improved the effectiveness and appropriateness of care and services provided for this consumer group. To achieve this we extended the management of the consumer’s health from a diagnosis driven medical model to a wider concept of health taking into account the consumer’s ability to manage daily activities in their home environment as well as preventative health to improve safety and reduce the likelihood of future health problems.

**Applicability to Other Settings**
The discharge risk screen and the revised assessment process developed during the project and used successfully in the ED could be equally effective in a preadmission clinic setting.
Evidence based Management Guides for Clinical Practice
Western Health - Division of Medicine, COGS, Aged Care and Rehabilitation Services, FOOTSCRAY, VIC

Author
Dr. Garry Lane              Head, Infectious Diseases Unit
Sofi Milenkovski           Coordinator, Clinical Service Redesign Programs

Abstract
The Day Procedure Lumbar Puncture and Bone Marrow Aspiration list provides a pain free option Western Health embarked on developing Clinical Management Guidelines based on the most current evidence for two major medical conditions, Heart Failure and Cellulitis. The clinical management guidelines were developed for senior and junior clinicians in General Internal Medicine units over three campuses of Western Health, Footscray, Sunshine and Williamstown. The purpose of the project was to provide clinical decision making guidelines for a group of patients with high incidence co-morbidities where clinical pathways or protocols were not appropriate.

The clinical management guidelines were developed to improve the quality of care provided to patients at Western Health by assisting in the coordination of their care, promoting consistency in clinical practice and reducing inefficiencies. Discharge education material was developed for Heart Failure and Cellulitis to assist patients with self-managing minor risk factors of their medical condition at home, thus minimising representations to hospital and also improving their quality of life.

Implementation of the clinical management guidelines have been a success in the organisation primarily due to identification of an appropriate clinical champion as well key stakeholders who engaged staff and drove the process. The development of the management plans required 8 months to ensure censuses was reached before implementing as a trial project in the General Internal Medicine units. The project was implemented with thorough and detailed education and information sessions to effect change throughout the organisation.

The evaluation of the project has resulted in improved quality of care for the patient that is based on evidence and best practice. This is illustrated by the increase in compliance with the clinical management guidelines as well as an improvement in clinical indicators over twelve months at Western Health.

Application of EQuIP Principles

Customer focus
- Consistent and efficient care provided to patients from admission resulting in a reduction in bed days in hospital.
- Improved patient management care as well as promotion for self-management with patient education material that has resulted in reduced readmissions to hospital.

Effective Leadership
- Senior executive sponsorship of change management project.
- Clinical champion to lead and drive the change.
- Complex change process across 3 treating units and 3 hospital campuses
- Dynamic team of key stakeholders to assist in driving the change.

Continuous improvement
- Clinical indicators identified to ensure clinical practice standards.
- Monthly monitoring of clinical indicators and compliance of the clinical management guidelines.
• Review and updating clinical management guidelines in response to updated evidence, monitoring and feedback.

Outcomes
The project achieved the following outcomes;
• Development of evidence based clinical management guidelines as a basis for treatment decisions in the management of Heart Failure and Cellulitis.
• Coordinated and streamlined care for patients with Heart Failure and Cellulitis.
• Increased compliance to specific clinical interventions established in management plans as clinical indicators
• Consistent and efficient patient care based on evidence or best practice.
• Unnecessary clinical practices eliminated with a result in reduced length of stay for the patient.
• Patient education material formulated
• Reduction in readmissions to hospitals

Striving for best practice
• Development of clinical management guidelines based on current evidence and best practice.

Applicability to Other Settings
• Process mapping of patient management
• Executive and clinical champion support
• Identification of appropriate key stakeholders
• Most current evidence compiled to formulate a compendium for an activity
• Development of clinical management guidelines for medical conditions to guide clinical making decisions
• Patient education material formulated to promote an awareness and to assist in self management of the disease
Falls Prevention: Falls Working Group and Falls Prevention Initiative
Osborne Park Hospital Program, Management Services, Stirling, WA

Author(s)
Aaron Cook   Clinical Quality Improvement Project Officer
Richard Johnson  Risk Management Coordinator

Aim
To reducing the number of inpatient falls at Osborne Park Hospital.

Abstract
A falls prevention initiative has been introduced to reduce falls and improve clinical practice and safety for patients at Osborne Park Hospital. The introduction of the Falls Working Group and SQuIRe Falls Prevention initiative is producing positive results in reducing the number of inpatient falls at Osborne Park Hospital.

Application of EQuIP Principles

Customer focus
• Involvement of Community Advisory Group members in Falls Prevention Initiative.
• Patient satisfaction surveys of falls prevention and harm reduction equipment.

Effective leadership
• Appointment of Clinical Quality Improvement Project Officer.
• Clinical Governance and Quality Improvement Steering Committee.
• Senior management and clinicians attendance at world class conferences.

Continuous improvement
• Spread positive falls interventions throughout each ward in hospital.
• Monthly audits of wards undertaking Falls Prevention initiative.

Outcomes
• Positive results of Falls Prevention Initiative since inception.
• Falls Prevention initiative (with other quality initiatives at Osborne Park Hospital) recognised with incentive funding from the Office of Safety and Quality (Department of Health).

Striving for best practice
• Appointment of Senior Research Officer to continuously investigate best and new practices for falls prevention, conduct data and trend analysis of Osborne Park Hospital statistics to identify potential areas for improvement and evidence of the success of current falls interventions.
• Falls Working Group and Falls Prevention Initiative team leader the recipient of Individual Contribution to Patient Safety award – Office of Safety and Quality in Healthcare.

Innovation
• Establishment of Falls Working Group and Falls Prevention Initiative with a multidisciplinary membership.
• Trialling various falls prevention and harm reduction equipment and strategies.
• Falls Prevention initiative Risk Matrix.
Applicability to Other Settings

- Falls is the number one clinical incident type across all of health in Australia.
- Simple, evidence based falls intervention strategies which do not require large amounts of funding, rather a positive organisational safety and quality culture cascading from Executive through to all staff.
Fast Track Colorectal Surgery – A Regional Base Hospital Experience
North Coast Area Health Service, Coffs Harbour Health Campus, Coffs Harbour, NSW

Author(s)
Dr Bill Ross   VMO Surgeon
Dr Ned Abraham  VMO Surgeon
Moya Anderson  Project Officer
Tracey Moore  Clinical Services Redesign Program Lead

Aim
To implement evidence based clinical practices to enhance post-operative recovery for patients undergoing colorectal resections in a regional base hospital will result in a 50% reduction in LOS and provide a better patient experience within 12 months.

Abstract
In recent years there has been much attention to health care costs, length of stays, timely access to elective surgical services and better patient experiences. Fast track colorectal surgery programs are multi-modal rehabilitation approach to patients undergoing colorectal surgery. The aim of fast track colorectal surgery programs is to reduce the patients surgical stress response, optimise pain relief and support early mobilisation and oral nutrition through the introduction of a range of evidence based interventions (Jackobsen et al 2006). Fast track colorectal surgery is evidenced to decrease patients LOS to 3-4 days without increasing GP visits, readmission rates or post-operative complications.

A review of the literature and current practice revealed that current practice was not based on the best available evidence. A review of the 85 patients who underwent colorectal surgery in the financial year 2004/2005 had an average length of stay of 12.1 days (Median 10 days) which was significantly greater than the length of stay for patients undergoing the Fast Track Protocol.

A working party was established to drive the implementation of the fast track protocol and included surgeons, anaesthetists, physiotherapists, dieticians and nursing staff and managers from pre-admissions, operating theatres, recovery, surgical unit and discharge planners and hospital executive.

The working party were provided with an overview of the fast track protocol including the evidence behind the interventions that form the fast track protocol such as:
- extensive pre-operative education
- carbohydrate loading 2 hours pre-operatively
- fasting 2 hours pre-operatively
- transverse incision
- nil routine use of naso-gastric tube or abdominal drains
- maintain intra-operative normothermia
- patient controlled epidural analgesia (PCEA) for pain management
- early mobilisation - 6 hours post surgery
- early resumption of diet
- post-operative protein drinks.

Since the implementation of the fast-track colorectal resection protocol there have been 24 patients who have undergone the fast track colorectal surgery protocol. The outcomes achieved include a reduction in median length of stay from 10 days to 6 days with nil adverse events related to the fast track protocol.
A patient satisfaction survey undertaken 28 days post surgery has revealed that there was a high level of satisfaction with the ‘fast track approach’ to colorectal surgery including education received pre-operatively, pain management post operatively and level of fatigue.

**Application of EQuIP Principles**

**Customer focus**
- The Fast Track Protocol focuses on reducing the patients surgical stress response, optimising pain relief and support early mobilisation and oral nutrition through the introduction of a range of evidence based interventions.
- Patients were consulted in the development of the education brochure.
- All patients are followed up 28 days post surgery to determine satisfaction with their surgical experience.

**Effective leadership**
- The implementation of the Fast Track Protocol was lead by one of the General Surgeons and supported by hospital executive.
- The pilot was well supported by a dedicated project officer, quality manager and project manager.

**Continuous improvement**
- The Fast Track Protocol has enabled a review of current practice to be undertaken and resulted in the implementation of evidence based interventions.
- Clinical audits are undertaken for all patients and variances and outcomes are monitored and feedback provided to the working party.
- Monitoring for reasons of delay in discharge are being reviewed to enable the median length of stay to reduced to Day 4.

**Outcomes**
- Reduction in median length of stay from 10 to 6 days.
- Nil adverse events related to the Fast Track Protocol.
- High levels of patient satisfaction with the Fast Track Protocol i.e. pre-operative education, pain management and level of fatigue post surgery.
- Pilot is now extending to the remaining general surgeons at the hospital.
- Development of evidence based clinical pathway to support the implementation of the Fast Track Protocol.

**Striving for best practice**
Fast Track colorectal surgery protocols aim to reduce the patients surgical stress response, optimise pain relief and support early mobilisation and oral nutrition through the introduction of a range of evidence based interventions.

**Innovation**
Coffs Harbour is one of only a few hospitals in Australasia who has implemented the Fast Track Protocol.

**Applicability to Other Settings**
- The Fast Track Protocol is equally transferable to any facility that performs colorectal surgery.
- Consideration for some aspects of the Fast Track Protocol such as pre-operative carbohydrate loading and only a 2 hour fast prior to anaesthetic is being considered for other surgical procedures.
Finding Your Feet
Gold Coast Health Service District - Home and Community Care (HACC) Services, CHARM (Community Health Assessment, Relearning and Maintenance Program), Palm Beach, QLD

Author(s)
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Physiotherapist for CHARM

Aim
The research aim was to assess the effectiveness of the Finding Your Feet (FYF) program.

Abstract
The Finding your Feet (FYF) program is a specific six-week intervention that aims to improve mobility, mobility confidence, balance and falls self-efficacy in older adults with a history of / or fear of falling. Like most balance-orientated therapy programs the FYF program addresses physical, environmental and medical issues. In addition it incorporates specific psychological components such as anxiety reduction, confidence building and coping strategies.

This evaluation study, incorporating a before and after design, recruited 152 people who attended the FYF in 2006. Data was collected at the beginning of the program and at six and 13 weeks after the program commencement.

The outcome measures included functional assessment (the timed-up-and-go (TUG) test, 180° turn test and 3-minute walk test), fall history, quality of life, mobility confidence visual analogue scale (VAS), Falls Efficacy Scale (FES) and a satisfaction survey. Demographic and clinical data were also collected by medical chart audit.

The participants in the FYF program all have a history of or fear of falling and live in their own homes. They were on average 80.6 years old with 74.3% being women and the majority had two or more co-morbid medical conditions. The results of the data analysis indicated that FYF program participants benefited from attending the program with statistically significant improvements in all outcome measures (except health related QoL) after 13 weeks. On average their functional abilities, their falls efficacy and their confidence improved significantly. In addition, the participants were very satisfied with the FYF program.

The FYF program is highly successful in not only increasing the functional mobility of the target group but it also increases their confidence and their interest in engaging in the community. While the results of this before and after evaluation need to be treated with some caution it appears that attendance at the FYF program has benefited this 'at risk' population.
Application of EQuIP Principles

**Consumer focus**
This research indicated that FYF program is meeting clients needs which focused on continuity of care. It also centered on access- no fee for service and transport was provided, ensuring that FYF clients had access to this service.

**Effective leadership**
This research demonstrated the FYF program is achieving excellence and which can be sustained.

**Continuous improvement**
The outcomes from the functional, QOL and satisfaction surveys showed that there was improvement in patient/ consumer quality of life which was sustainable.

**Outcomes**
The results of this research focused on safety and indicated that clients improved significantly in their function, quality of life and reduced their falls risk which was sustained over a 3 month period.

**Striving for best practice**
Results indicate that the appropriate interventions were used and desired outcomes for patient / consumer were achieved and sustained over a 3 month period. Results also demonstrated that FYF was very effective.

**Innovation**
The FYF program incorporates specific psychological components such as anxiety reduction, confidence building and coping strategies.

**Applicability to Other Settings**
Elizabeth Aire has been seconded by Population Health to develop a facilitator’s kit for the FYF program so that other agencies can implement it.
Health Promotion Training and Support Framework
Southern Health, Quality Unit, Clayton South, VIC

Author
Emma Bruce  Health Promotion Executive Officer

Aim
To strengthen the capacity of Southern Health staff, stakeholders and community in the Southern Health catchment to further develop good practice health promotion knowledge, skills, initiatives and systems.

Abstract
Southern Health was registered with the World Health Organisation in 2007 as a health promoting health service. Before this registration, it was agreed a comprehensive training and support framework for health promotion was necessary. An integrated health promotion plan was developed with the priority of capacity building. This plan outlines strategies aimed at increasing the capacity of Southern Health staff to be involved in good practice health promotion. They are as follows:

Health Promotion Reference Group (HPRG)
The HPRG was formed to provide leadership for health promotion, initially for Primary Care and now for all Southern Health. This group acts as a reference point for health promotion strategic planning and leads the implementation of the Health Promotion Strategic plan. There are representatives from many Southern Health services, providing broad representation for health promotion.

Introduction to health promotion workshops
The Southern Health Introduction to Health Promotion was developed to provide staff with an overview of health promotion principles and theory. It was also developed with the understanding that most staff are not funded for health promotion and therefore have limited capacity to be involved. Staff complete an evaluation about their health promotion knowledge, with results showing the workshop increases staff confidence and knowledge of health promotion.

Online introduction to health promotion
An online introduction to health promotion was created to provide exposure to the maximum amount of Southern Health staff. The online version was adapted from the workshop version and is available on the Southern Health intranet. This online training session is compulsory for all Southern Health Primary Care staff annually and covers the principles of health promotion and thinking. It is yet to be evaluated.

Health promotion mentoring
A health promotion mentoring program was developed in response to feedback from the introduction to health promotion workshops. After consultation with the HPRG and other senior health promotion staff, it was decided a mentoring program would provide the necessary knowledge and support. Staff are matched with a health promotion practitioner, provided with knowledge and support to implement their learnings, and set goals together. The mentoring model is yet to be evaluated.

Why invest in health promotion workshop
Management commitment at various levels is necessary if health promotion is to be part of core business. Therefore, a training package for managers - “Why Invest in Health Promotion?” - was developed. The module provides managers with an overview of health promotion and the benefits of investing staff time.
This comprehensive approach to health promotion training and support ensures that Southern Health staff are well equipped to meet the requirements of being a “health promoting health service”.

Application of EQuIP Principles

Customer focus
The approach to the health promotion training and support has been informed by consumers (Southern Health staff) as it was developed by the HPRG which comprises representatives from Southern Health services.

Effective leadership
- Effective leadership is vital if the training and support framework is to succeed.
- Leadership from the HPRG and the appointment of an executive sponsor for health promotion has meant that health promotion has a profile across the many levels of Southern Health.

Continuous improvement
- A thorough evaluation process involving both qualitative and quantitative methodologies is an ongoing feature of this intervention.
- The evaluation results inform the future planning so as the intervention continues to meet the needs of the target group (Southern Health staff).

Outcomes
So far, outcomes have been process oriented and include the development of the online introduction to health promotion and the delivery of the Introduction to Health Promotion Workshop. Evaluation suggests this has increased staff knowledge and confidence in health promotion. To make these outcomes sustainable, the mentoring program and the managers’ module will ensure the learnings are translated into investment in good practice health promotion across Southern Health.

Striving for best practice
All strategies in this intervention are informed by the latest research regarding capacity building for health promotion. The evaluation process ensures that the interventions continue to be informed by evidence.

Innovation
- This approach to health promotion capacity building across a health service is both innovative and unique.
- Southern Health are leaders in their approach to health promotion and this training and support framework adds to this leadership.

Applicability to Other Settings
This approach has the potential to be replicated in any health service with a strong commitment to health promotion.
Improvement in the Management of Paediatric Fever Presentations in the Emergency Department
Armadale Health Service, Emergency Department, Armadale, WA

Author
Helen Flavell   Medical Officer

Aim
To improve the quality of care provided to our paediatric patients presenting with febrile illnesses.

Abstract
An audit was conducted of patients under the age of three years presenting with fever to our emergency department to identify areas for quality improvement. In the light of the findings we undertook education of nursing and medical staff, the introduction of a paediatric proforma and review of our current guidelines. A follow up audit showed documentation of toxic signs improved from 62% to 86%, urine collection increased from 68% to 86% and adherence to protocols improved from 60% to 82%.

Application of EQuIP Principles

Consumer focus
• The changes made aim to improve the quality of care provided by our hospital to the increasing paediatric population.
• The involvement with local general practitioners and community health nurses aim to help with follow up care when children are discharged.
• Encouraging parents to return if they are concerned regardless of the time of day or how long it has been since they have been assessed.

Effective leadership
• The involvement of all staff in the process of improvement and encouraging feedback so that concerns and any obstacles to change can be considered.
• Ongoing education of staff so they are informed of the reasons that change is required.
• Incorporating the local general practitioners and community health nurses to achieve our aims.

Continuous improvement
• Reviewing the guideline to ensure all paediatric patients were incorporated.
• Ongoing audit cycles to monitor outcomes, identify areas of unmet need and looking at ways of improving these.
• Incorporation of increased paediatric bays in our future emergency department.
• The management of headache and abdominal pain presentations is now being assessed for the adult population.

Outcomes
• Documentation of toxic signs improved from 62% to 86%.
• Urine collection increased from 68% to 86%.
• Adherence to protocols improved from 60% to 82%.

Striving for best practice
• Discussions with our local paediatric referral hospital to compare our management.
• Improved quality of care provided to our paediatric patients.
Innovation
- Review of the whole process of triage, documentation, investigations and management.
- Incorporating the whole emergency “team” to take ownership of the problem.

Applicability to Other Settings
- This process can be undertaken in any emergency department managing febrile children.
- As these are low cost interventions they are easier to apply.
Improving Clinical Handover
Royal Perth Hospital, Clinical Services, Perth, WA

Author
Samantha Perryman  Project Officer, RPH Clinical Safety & Quality Unit

Aim
To identify practical tools, strategies and resources that assist clinicians to improve the quality of handover communication.

Abstract
Ineffective clinical handover presents significant risks to patients. Standardisation of clinical handover content and processes has been identified as a priority for quality improvement work by the World Health Organisation. A pilot project aiming to improve information transfer between nursing shifts was conducted on an acute medical ward at Royal Perth Hospital through implementation of a semi-automated, electronically generated handover sheets. Senior nursing staff on the pilot ward, recognising the potential to save time and improve the quality of patient information, took ownership of the change process. The pilot ward team consistently worked toward standardisation of handover information, developing handover categories essential to the clinical and operational needs of a busy ward. An unused function of an existing electronic application generated handover reports, with the advantage of inbuilt accountability and tracking functions. This new handover report format has addressed risks previously identified for the existing handover format.

Application of EQuIP Principles

Consumer focus
• Clinical handover essentially communicates patient needs, incorporating a fundamental consumer focus.
• Presenting key patient information and identifying risks in a patient focused format.
• Utilising an electronic tool to standardise and enhance communication.
• Aiming to improve effective clinical communication across the continuum of care.
• Using an existing clinical application that maintains the integrity of handover information, even when the patient changes location.

Effective leadership
• Ongoing commitment of pilot ward staff to improve the process of communicating patient information from shift to shift.
• Significant benefits to ward staff were realised, presenting a solution to problems with the existing system.
• Senior staff embraced an opportunity to reduce patient risk and save nursing time.
• The impact of change was minimised through local ownership of the project initiative.
• The development of a standardised handover report meets a need within a large organisation, by encouraging more effective forms of communicating patient information.
• Wider interest has been generated within the organisation and a feasibility assessment of wider trialling and implementation is in progress.

Continuous improvement
• Successful in implementation of an improved form of communication between clinicians.
• Ward staff, as users of the system and champions of change, continuously review the content and accuracy of information in the handover reports.
Feedback can be provided to individuals entering sub-standard information as the application logs which user adds each piece of information.

Issues relating to refining the standardised handover categories and reporting of potential or actual problems with the initiative are addressed through ward-based meetings.

Auditing can currently be done prospectively at the point of care, or retrospectively by running reports.

Initial evaluation has identified areas for further improvement and generated a number of potential solutions for other clinical projects in progress.

Outcomes

- The pilot project has provided a novel communication solution that encourages clinicians to review and improve upon their clinical communication processes.
- Adoption of a standardised process potentially reduces risk to patients where systems of communication are at risk of breaking down.
- The ‘new system’ was found to be relatively easy to teach, with staff grasping the concepts and skills required to make the project work.
- The initiative has been accepted as a permanent change to the handover process on the pilot ward, reverting back to the old system of handover was not considered to be safe practice.

Striving for best practice

- Review of handover processes, development of solutions and sharing effective strategies is the current challenge for healthcare providers and clinicians and has been addressed through this pilot.
- Industry benchmarks and best practice for clinical handover are currently in development.
- Problems and risks of ineffective clinical handover are well documented and efforts to provide ongoing transferable and sustainable solutions will inform and benefit future work in this area.

Innovation

- The initiative presented a cost-effective a novel solution for improving communication.
- Utilising an existing clinical computer application for the initiative had the advantage of maintaining secure patient information and minimising training requirements.
- Interest from other units and sites demonstrates the potential for providing a global standardised solution.

Applicability to Other Settings

- Risks to patient safety from ineffective handover are an international concern.
- This initiative has the advantage of incorporating a minimum information dataset with the ability to individualise additional required data and present patient information in a format that suit the workflow and clinical needs of a unit.
Improving Outcomes in Patients Requiring Dialysis Without a Permanent Dialysis Access
Concord Repatriation and General Hospital (CRGH), Renal Unit, Concord, NSW

Author(s)
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Glenn Stewart  Renal CNC
Josette Eris  Director of Statewide Renal Service, Sydney South West AHS

Aim
To reduce the burden of exposure to temporary dialysis catheters and the serious complication of catheter related bacteraemia in patients requiring dialysis without a permanent dialysis access.

Abstract
A leadership group was formed which included a Renal Physician, Vascular Surgeon, Vascular Surgical Registrar, Radiologist, Anaesthetist, Renal Nurse Consultant, Vascular Nurse Consultant and an Infection Control Nurse, with the intention of addressing the dual aims of the project.

Initial measurement of the processes associated with temporary dialysis access highlighted a number of issues. At a meeting in February 2006 a series of interventions were agreed upon, including:

- Patients who were likely to require a surgical procedure should be referred to the Vascular Surgeons and operated upon as soon as medically fit.
- Temporary dialysis catheters inserted into the femoral vein would be discouraged within the Unit and wherever possible, replaced with a catheter in another vein.
- The Renal Nurse Consultant would oversee all patients with catheters in situ and ensure their removal as early as medically feasible.
- A standardised dressing technique would be developed by nursing staff.
- Where possible, temporary dialysis catheters would be inserted with a longer subcutaneous tunnel and those without a subcutaneous tunnel would be discouraged and replaced with tunnelled ones (where feasible).
- Regular feedback of the data on progress to all stakeholders.

The dual objectives of the Project team have been achieved over the last 18 months, significantly reducing the burden of discomfort, risk and hospitalisation for patients:

- Fewer temporary dialysis catheters are being used in patients, with the average number of catheters required per episode of dialysis access insufficiency falling from 1.7 catheters / episode in 2005 to 1.26 in 2006 and 1.13 so far in 2007.
- The rate of bacteraemia has also fallen by 65%, from 4.11 episodes/1000 catheter days in the first 6 months of the project compared with 1.38 episodes/1000 catheter days in the most recent 6 months. On current usage rates, this represents prevention of 15 episodes of bacteraemia per year.

Improvements in the main outcomes of this project were supported by clear changes in some of the other outcomes measured, such as:

- The proportion of catheters that were removed due to concerns about infection fell from 21% in the first 9 months of the project to 7% in the last 9 months.
- The proportion of total line days associated with catheters in the femoral vein (a recognised risk factor for infection) fell from 9% to 2% between the first six months of the project and the last 6 months.
The proportion of total line days associated with tunnelled catheters (which have a lower infection risk) increased from 80% to 98% between the same time periods as above.

**Application of EQuIP Principles**

**Customer focus**
This project has reduced patient discomfort associated with the insertion of temporary dialysis catheters as well as the life threatening complication of bacteraemia.

**Effective leadership**
- Data has been presented to various units and at Grand Rounds, illustrating to the organisation what can be achieved.
- The project has inspired our staff to develop further improvement projects.

**Continuous improvement**
- Continuous data feedback to all stakeholders.
- Gradual improvement over time, to current levels of world’s best practice.
- Building on existing outcomes to develop further projects.

**Outcomes**
The major outcomes have been illustrated through a robust measurement process and supported by other measurable changes in our processes.

**Striving for best practice**
Our latest outcome data is better than most reported in world literature.

**Innovation**
- A systematic application of a number of innovations with clear dual objectives.
- The development of an innovative dressing method by nursing staff, using antibacterial honey, as part of the project.

**Applicability to Other Settings**
- All Renal Units struggle with the complications of temporary dialysis catheter placement and the interventions used here are affordable and accessible for all.
- Catheter related bacteraemia is a major problem in all hospitals and many of the techniques used in this project have wider applicability for the general hospital setting, beyond the Renal Unit.
Improving Quality of Life by Increasing Social Activity
Hornsby & Ku-ring-gai Health Service, Mental Health, Hornsby, NSW

Author(s)
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Aim
The aim of the project was to increase social activity of consumers attending the Early Psychosis Intervention Service (EPIS).

Abstract
A Clinical Practice Improvement project was conducted. Consumers and carers were part of the project team. Interventions included:

- An after-hours social activity organised by EPIS staff but consumers only present.
- An extensive directory of social and leisure activities in the local area produced and distributed to consumers.
- EPIS clinicians put greater emphasis on encouraging carers to facilitate more social activity for their family member.

Outcomes
33% of EPIS clients have participated in NightWorks. 80% of clients participating demonstrated a reduction in social withdrawal and/or an improvement in the ability to sustain friendships since commencing the programme. (As measured by the assessment tool ‘Life Skills Profile’).

Application of EQuIP Principles

Customer focus
- Focus groups were held and feedback surveys given for both consumers and carers to determine the nature and extent of the problem.
- Interventions focused on ‘normal’ activities and encouraged consumers to participate in social and leisure opportunities within the local community.

Effective leadership
- High level support from EPIS team.
- CPI team leaders included customer focus throughout the project, including members on the CPI team.

Continuous improvement
- An after-hours activity ‘NightWorks’ initiated.
- Consumers will be invited to the EPIS annual planning day where feedback on the issue will be invited.
- All Family Education Programmes for new families (held 2-3 times a year) will include a segment on improving social activity.
- Annual surveys will be given to EPIS consumers eliciting their feedback on social activity.
- Annual focus groups for consumers will be held to review progress and to elicit further initiatives.
Outcomes
- 33% of EPIS clients have participated in NightWorks.
- 80% of clients participating demonstrated a reduction in social withdrawal and/or an improvement in the ability to sustain friendships since commencing the programme.
- Eight events now held.

Striving for best practice
- The experience of the EPIS team and feedback from consumers and their families confirm that the positive symptoms of psychosis respond well to antipsychotic medications.
- Many young EPIS consumers are left with persistent and disabling negative symptoms. Evidence of the disabling effects and poorer outcomes for individuals with significant negative symptoms has been well documented in the literature (Dennis et al 2000).
- Of particular concern has been the impact of negative symptoms on the consumer’s level of social activity.

Innovation
- To improve participation and relevance, consumers (patients and their carers/families) were involved in all aspects of this project.
- Gaining insight into the needs of young adults enhanced the effectiveness of the “Night works” program.

Applicability to Other Settings
The process of working with consumers and carers in partnership with health professionals could be applied to a range of health areas.
Improving Triage and Emergency Documentation in District Hospitals
WA Country Health Service- South West (WACHS-SW), BUNBURY, WA

Author
Ceri Elliott
Pauline Crommelin

Aim
The project aimed to develop a standardised emergency assessment document for district hospitals (without salaried medical officers), which would aide nurses in allocating a triage score based on an auditable, clinical decision-making process.

Abstract
Triage refers to the process of sorting emergency patients according to need for treatment. The Australasian Triage Scale (ATS) is a clinical tool to help prioritise care. The current Western Australian Department of Health document for emergency notes (MR1) used at WACHS-SW district hospitals is insufficient in demonstrating sound clinical judgement when allocating a triage score. This was highlighted in an audit of emergency nursing documentation at district hospitals. The inadequate allocation of a triage score can result in overlooking serious conditions that have resulted in wrongful death, due to a delay in emergency treatment. Additionally, a poor decision could result in lower than adequate triage score, which the state then interprets as a lower acuity department. This, in turn, could affect the funding allocation for nursing hours for emergency care. An audit of 100 MR1s was undertaken at a district site. There was little evidence in the nursing documentation to demonstrate that any sound clinical decision-making process was used when assessing patients and allocating a triage score. The review of triage documentation was then extended to the remaining 11 districts without salaried medical officers. There are around 67,000 emergency presentations annually. A draft MR1 (Version 2) was developed, trialled and evaluated. It involved local Medical Advisory Committee (MAC), nursing and clerical staff at the district. A reaudit of medical records was undertaken which demonstrated an improvement.

Application of EQuIP Principles

Customer focus
Forms met the clinicians (medical, nursing and health information) needs as well as the invoicing needs of the visiting medical officers.

Effective leadership
• Collaboration between all disciplines
• Change management within the districts

Outcomes
• Auditable decision making emergency department notes was developed (MR1 V3)
• Clinical decision making framework for triage score allocation
• Standardised emergency notes at district hospitals without salaried medical officers
• Improvement in triage scores at pilot site

Striving for best practice
Timeliness to care was a best practice outcome of this project in line with key performance indicators for triage.
Innovation
was needed to accommodate the specific needs of the medical staff in rural settings who used this
document to invoice the health service (fee for service).

Applicability to Other Settings
The current MR1 (V4) is currently being rolled out to the 10 other district sites. It can be applied to
other health facilities.
Innovations in Care: Palliative In-home Respite
Silver Chain Hospice Care Service, Osborne Park, WA

Author(s)
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Michelle McClure  Business Improvement Coordinator Relief Support Manager

Aim
To provide a comprehensive and cost effective in-home respite service which enables palliative care clients to receive terminal care at home if this is their chosen place of care.

Abstract
In-home respite is an important component of client and family care. Most palliative care clients want to remain at home for terminal care but this is not always achieved. Silver Chain Hospice Care Service acknowledges that receiving terminal care in the place of choice is an important for both the client and carer. Following extensive research and testing of a pilot program an in-home respite service has been incorporated into the hospice care service.

Application of EQuIP Principles

Customer focus
- Silver Chain Hospice Care Service has an interdisciplinary approach to care, with the client and family as integral partners in care planning.
- Clinical, psychosocial and spiritual care is provided from the perspective of the client and family.
- A clinical pathway which encompasses assessment from admission to terminal care is used to guide care provision.
- Criteria within the clinical pathway includes carer strain, therefore providing cues which highlight need for in-home respite.
- In-home respite is provided as requested by family and / or client.
- In-home respite is also provided for clients who live alone.

Effective leadership
- The Silver Chain Hospice Care Service management team incorporates representatives from all disciplines; nursing, medical, chaplaincy, counselling and administrative.
- Audits, surveys and key performance indicators are utilised to monitor standards of care.
- Gaps and deficiencies are addressed to ensure optimal care is provided to clients and families.
- All staff is encouraged to maintain expertise through continuing education activities and to disseminate information through presentations and publications.

Continuous improvement
- Silver Chain Hospice Care Service encourages all staff, clients and families to complete continuous improvement forms outlining areas of concern and suggestions for change.
- Suggestions regarding the in-home respite service have been evaluated and deficiencies addressed. The respite service is now available to all clients / families receiving care from the hospice service.
- Key performance indicators are utilised to determine current service performance issues.
- Internal benchmarking between the three service delivery centres is carried out with outcomes discussed at each centre with staff.
• Research forms a pivotal component of continual improvement and in-home respite is an example of a research project that has resulted in implementation of a new program.

**Outcomes**

• Outcomes of key performance indicators and auditing activities provide data relating to key processes and results. The outcomes are utilised to determine areas which require attention.
• Information is utilised to develop strategies which will promote improved service to the client/family.
• The clinical review group assess client’s notes to determine any issues/concerns that may have arisen and the outcomes are disseminated to the clinical team for discussion. This promotes the use of in-home respite for clients who want to remain at home.

**Striving for best practice**

• Managers from within Silver Chain Hospice Care Service have visited agencies within Australia to compare services.
• Complex needs of clients prevented replication of other models of care within the Silver Chain Hospice Care Service, therefore pilot testing and evaluation of model of in-home respite service was carried out prior to implementation.
• Silver Chain Hospice Care Service has been appointed as the lead agency in a national research project which is aimed at benchmarking quality indicators.
• The service is also actively involved in two of the Western Australia Cancer and Palliative Care Network projects; Paediatric Palliative Care and the Pathways Project. The aim of all projects is to improve client/family outcomes.

**Innovation**

• Silver Chain Hospice Care Service carried out a comprehensive analysis of client data to determine the number of clients who wanted to die at home but were unable to do so.
• Development of a comprehensive and cost effective in-home respite service utilising respite carers with varying skill mix ensuring client/family requirements are met.

**Applicability to Other Settings**

• Increasing numbers of individuals requiring palliative care are receiving complex and time consuming care within their homes, with care provided by family carers who may experience many stressors which ultimately results in hospital admission for the client.
• In-home respite is a cost effective component of enabling the family to maintain care at home or supporting the client who lives alone to remain at home for terminal care.
Innovation in Falls Prevention and Physical Activity for Older People
Peninsula Health, Falls Prevention Service and Ageing Well & Improving Care Unit, Frankston, VIC

Author(s)
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Karen Bull  Manager, Ageing Well & Improving Care

Aim
Using a collaborative approach, to increase the number of older people with chronic or age-related conditions, who have access to information, programs and services for Falls Prevention, Strength Training and Physical Activity.

Abstract
A multi-strategic initiative, to facilitate optimal mobility and functioning in older people, involved three major components:
1. Development of a modified strength and balance program, called Agestrong.
2. A broad falls prevention strategy, across the health service and community.
3. Promotion and development of physical activity options for older people.
All components of the overall strategy involved establishment of collaborative partnerships, within the hospital setting and in the community.
A range of programs now exist across the continuum and in the community, to support older people to maintain optimal mobility, prevent falls and to access appropriate services and programs according to need. These include:
- An evidence based strength and balance program, called Agestrong.
- The production of a region-wide directory to list physical activity programs for older people within the community.
- Development of Community Falls Education booklet “A Guide to Preventing Falls”, - now utilized by other health services such a Benetas, Regis, Campaspe Shire, Life care SA.
- Development of 3 supported indoor walking programs within local shopping centres. These groups attract up to 90-100 walkers each walk day, up to 3 days per week.
- Delivery of an Ageing Well Expo in 2006, attracting 1000 participants, to be repeated in 2007.

Application of EQuIP Principles

Consumer focus
- Initiatives were introduced based on consumer need.
- Consumers provide routine feedback which is reported on and actions taken within the quality Improvement program.
- To optimize access according to need, these programs are available in the community and across the continuum.
- Clinical Indicators developed in relation to overall participant satisfaction with program.

Effective leadership
- Formation of effective interagency partnerships over an extended period.
• Agencies engaged who traditionally do not deliver "preventative intervention."
• Extensive skill, knowledge and resource sharing to facilitate cost effectiveness and sustainability.
• Development of Falls Portfolio holders ensures falls prevention competency.
• Falls prevention and Agestrong have been presented at several conferences.

Continuous improvement
• Supported by a sound quality framework, incorporating education, auditing, compliance reporting and falls portfolio roles.
• Consumers provide routine feedback for Agestrong and Falls Prevention which is reported on and actions taken within the quality Improvement program.

Outcomes
Quality Indicators have been developed and are reported on a three monthly basis to the Quality and Clinical Governance Committee. (See full report)

Striving for best practice
• All initiatives have involved extensive review of best practice.
• Involvement in best practice guidelines development for falls prevention (see outcomes section).
• Agestrong and Falls prevention were acknowledged by the Australian Council on Healthcare Standards - Organization Wide Survey (February 2007), as an “Excellent example of researched evidence-based practice, in use across inpatient, community and residential settings.” (Australian Council on Healthcare Standards).

Innovation
• Development of an evidence based strength training program for a particular target group.
• Development of training resources for upskilling.
• A broad population approach to physical activity including program development in an identified area of need.

Applicability to Other Settings
• The applicability to other settings is demonstrated by the inclusion of tools developed in State and National guidelines and wide use of resources.
• The inpatient Falls Program has been successfully implemented into local residential settings.
• Agestrong is attracting interest by the Department of Victorian Communities as a model for Rural communities- discussions in progress.
• Peninsula Health has now been selected by the Department of Human Services as the Lead Agency for the development of a state-wide resource for best-practice in ‘Mobility, Vigour and Self Care’ a strategy for the Prevention of Functional Decline in hospital and community settings. This project will involve the sharing of Falls Prevention and mobility resources for development of a best-practice toolkit.
Innovations in Clinical Variance Analysis  
St Andrew’s Toowoomba Hospital, Clinical Services, Toowoomba, QLD

Author  
Fiona Brown  Director of Clinical Services

Aim  
To develop and implement a suitable method of clinical variance analysis.

Abstract  
St Andrew’s Hospital Toowoomba completed ACHS Periodic Review in May 2006. A recommendation from periodic review was to implement a process for clinical variance analysis:  
Recommendation: A Plan be developed to conduct clinical analysis on targeted clinical pathways, in order to determine the effectiveness of the pathway in providing specified patient outcomes.

Clinical Pathways were widely used with staff completing variances, however the variances were filed with the patient medical record and no analysis of the variance was ever completed.

Information required to review the clinical pathway variances was identified and an excel spreadsheet was developed by the Director of Clinical Services to collect variance information. Clinical Variance Analysis was added as a key performance indicator to the Senior Nursing Management Committee agenda to ensure ongoing review of the effectiveness of pathways.

Further refinement of the variance analysis process was facilitated by the development of a Clinical Variance Analysis intranet based database by the hospital Information Technology team. The database is accessed with a password and allows easy input of variance information for review.

Monthly variances are automatically collated into a report which can be reviewed at the Senior Nursing Management Committee, allowing identification of variances which may need to be incorporated into the clinical pathway, or which may suggest an improvement in patient outcomes by a change in practice.

Clinical Variance Analysis is now a simple process where ongoing review occurs.

Application of EQuIP Principles

Evaluation Process  
Evaluation of the clinical variance analysis database, it’s reporting capability and the variances identified are reviewed monthly at the Senior Nursing Management Committee. Improvements are identified at a Committee level and implemented as a priority.

Effectiveness  
The effectiveness of the Clinical variance Analysis database is evaluated monthly at the Senior Nursing Management Committee. Additional variance codes are identified and added to the database as required. The database is a living platform which is revised and updated as required.

Sustainability  
The clinical variance analysis database is completely sustainable with no ongoing reliance on a particular role. Although the Director of Clinical Services is the current administrator of the database this role can easily be performed by the Information Technology team. Clinical managers are now accustomed to the process of variance analysis and while variance analysis remains a key
performance indicator at the Senior Nursing Management Committee, it will remain a focus for all clinical managers.

Innovation
The clinical variance analysis database is innovative because in the majority of clinical settings this clinical variance analysis process is managed by a cumbersome excel tool which is not simple to use or pull reports from. The other alternatives in many facilities is a paper based process for review. The intranet based database allows easy input by staff and easy report compilation for the review process.

Applicability to Other Settings
The Clinical Variance Analysis database tool could very readily be made available to other facilities for use.
Integrated Adult Mental Health Services
Hunter New England Health, HNE Mental Health Service / The Maggie Program, Newcastle, NSW

Author(s)
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Megan Turrell
Roslyn Barker

Aim
The aim of the project was to develop an integrated model of care that links inpatient and community mental health services across Hunter New England Health to better meet the needs of consumers.

Abstract
An Adult Community Mental Health Project was conducted in Hunter New England Health between June 2006 and April 2007. The project methodology incorporated a staged approach including planning, diagnosing issues, solution design, implementation and evaluation. Strong leadership and local ownership was combined with consumer input to design and implement an integrated model of care for Mental Health services. This included clarification of the Mental Health Model of Service and improved discharge planning as a coordinated care model between the inpatient unit and community care settings. Processes were realigned to enable collaborative relationships between care providers to better meet consumer needs. The changes have led to significant improvements in both the inpatient and community mental health settings. The model of care is innovative and has applicability to a range of health care services.

Application of EQuIP Principles

**Consumer focus**
The project was aimed to improve the consumer journey and redesign services to better meet consumer needs. Consumers and carers were interviewed, they participated in focus groups and were key participants in the redesign workshops and project management meetings. The redesign process was conducted from the consumer perspective which assisted in overcoming many of the traditional professional barriers in healthcare, and ensured that the voice of the consumer and carer were central at each stage. This led to a set of implemented solutions aimed at improving services from the consumer perspective.

**Effective leadership**
The project was led by the service Director and supported by the Area Executive Team. The solutions were led from the top and involved staff in the redesign of the services.

**Continuous improvement**
Local performance improvement teams have been established to review ongoing processes, evaluate and monitor outcomes. Outcome data is showing sustainability and continuing improvement across many indicators of care.

**Outcomes**
Improved performance indicators across inpatient settings and increased clinical time for community mental health practitioners.

**Striving for best practice**
Best practice has been identified in the project solutions and implemented across the service.
Innovation
The Hunter New England Health Mental Health Integrated Model of Care is an innovative model of best practice.

Applicability to Other Settings
The model is applicable to other Mental Health services and may have applicability across health care settings where the patient journey crosses multiple types of inpatient and outpatient services.
Looking Ahead: Returning to School After an Acquired Brain Injury
Greater Newcastle Acute Hospital Network, Paediatric Brain Injury Rehabilitation Team: Kaleidoscope: Hunter Children's Network, New Lambton, NSW

Author(s)
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Aim
The aim of “Looking Ahead” is to ensure education staff have timely access to specialised information on Acquired Brain Injury (ABI) in children to enable early identification of learning and classroom difficulties.

Abstract
Neurorehabilitation of children and adolescents after an Acquired Brain Injury (ABI) usually involves a multi-disciplinary team approach and begins in a hospital setting. The majority of children who sustain a significant ABI return to school. The coordination of health and education services plays an important role in achieving successful rehabilitation outcomes for the child.

Kaleidoscope’s Paediatric Brain Injury Rehabilitation (PBIRT) Team desired to create a DVD resource for teachers and schools that would provide valuable information to understand the effects of brain injury and ways of assisting these students. Content includes a “feature” describing a child’s journey from hospital back to the classroom and playground. It contains interviews with team members outlining their roles, interviews with parents describing the challenges experienced in their child’s return to school, and a collection of guides for teachers including printable curriculum-referenced material.

To date over 350 DVD/CD Rom’s have been distributed across New South Wales (NSW), including rural, regional and metropolitan schools. Education staff within PBIRT’s area were offered instruction on the applications of the DVD/CD Rom. Brain Injury Staff across NSW will provide a child’s school with the resource when a child is referred to their service.

Application of EQuIP Principles

Customer focus
- DVD/CD Rom designed specifically for education staff.
- Consultation with education staff throughout the planning and implementation stages of the project.
- Key areas of the resource prioritised by teacher focus groups.

Effective leadership
- Empowers teachers to make informed decisions about strategies and intervention for children with an ABI.
- Enhances service delivery to families and schools in rural and remote areas with limited access to health services.
- Uses information technology as an innovative service delivery approach to children and schools over a vast geographical setting.
Continuous improvement

- Health staff identified key areas to address when providing information on ABI to schools. A DVD/CD Rom was a solution.
- Education staff were consulted continuously during the planning process of the DVD/CD Rom.
- Education staff feedback highlighted the need to expand project to include a strategy document.
- Marketing and distribution plan devised to facilitate awareness and access.
- Plans to maintain awareness through marketing and provision of resources to other brain injury services across NSW.

Outcomes

- Over 350 DVD/CD Rom’s distributed across NSW including regional, rural and metropolitan schools and PBIRTs.
- Education seminar provided to Disability Support Personnel in Department of Education and Training, Catholic School of Education and Association of Independent Schools.
- Education staff reported the resource as highly useful and applicable within the classroom and play ground.

Striving for best practice

- Resource that reflects consultation and collaboration with other brain injury services and education staff.
- Functional strategies to be used within the context of their school.
- Consistency of care within the school.

Innovation

- First comprehensive Australian-based information package on ABI in children which has been designed for schools.
- Uses information technology to enhance service delivery.
- Teacher can use resource as needed.
- Presenting health information using teaching categories and terms.
- Utilising education services to continue care in rehabilitation.
- Collaboration between health and education to produce an effective resource.

Applicability to Other Settings

- DVD format could be used with other disabilities, such as autism spectrum disorder.
- DVD/CD Rom has received positive feedback for its use within educational facilities within Queensland, United Kingdom and New Zealand.
Medication Reconciliation – Reducing Medication Errors
Royal North Shore Hospital & Hornsby Ku-ring-gai Hospitals, The Northern Therapeutics Unit, Departments of Pharmacy and Clinical Pharmacology, Division of Medicine, NSCCAHS, St Leonards, NSW

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Aim
This project aimed to reduce the risk of adverse drug events (ADEs) by improving the accuracy of medication histories recorded on admission through development of a sustainable medication reconciliation process.

Abstract

Introduction
The Safer Systems Saving Lives (SSSL) – Preventing Adverse Drug Events (ADEs) project was performed at Royal North Shore (RNSH) and Hornsby Ku-ring-gai Hospitals (HKH) from May 2006 to March 2007. The project aimed to reduce the risk of ADEs by improving the accuracy of medication admission histories recorded on admission. We aimed to achieve this by developing a sustainable medication reconciliation process.

Method
A Medication History on Admission Form (MHAF) was introduced into the Emergency Departments at both sites and in two wards at RNSH. The form enabled documentation of the four care components of medication reconciliation: medication history on admission, confirmation with a second source, reconciliation of medication orders with history, and medication liaison. Medical, nursing and pharmacy staff received education on the form and medication history taking. 20 patients were audited each month for compliance with the care components. In addition 50 patient charts were audited pre and post the intervention for medication errors.

Results
The proportion of patients receiving the care components increased at RNSH with the introduction of the Medication History on Admission Form and at HKH with the Medication History on Admission Form and the addition of a part-time emergency department pharmacist. Both sites observed associated improvements in the accuracy of admission medication histories recorded and in detection of drugs omitted. At RNSH, the proportion of patients receiving all four care components increased from 66% at baseline to 91% after the intervention and errors in admission histories decreased by 33%. At HKH, errors in medication histories on admission dropped from 69% to 25% after medication reconciliation was implemented.
Conclusions
The project demonstrated the benefits to patient safety from using a medication admission history form that facilitates the medication reconciliation process, improves the standard of medication histories on admission and reduces medication errors. The form proved effective in hospitals of differing size and complexity.

Application of EQuIP Principles

Customer focus
- Patient care was improved by reduction of medication related errors.
- Increased participation empowered patients and carers to contribute information to their care plan.
- Patients were provided with additional education to improve understanding and concordance of their medications.

Effective leadership
- This was essential to effectively direct resources at each site and ensure that a consensus was reached in complex environments.
- The recent formation of The Northern Therapeutics Unit, which consists of Clinical Pharmacology, Clinical Pharmacy and Academic Pharmacy, facilitated the multidisciplinary leadership and implementation of the study.
- The team was supported by the Clinical Governance Unit.

Continuous improvement
- Baseline audits allowed an accurate assessment of the nature and extent of the problem.
- Ongoing audit provided data that the project was reducing medication errors and enhancing patient care.

Outcomes
- RNSH showed an increase from 66% of patients receiving all care components at baseline to 91% after the intervention.
- Confirmation of medication history increased from 78% to 100% of patients audited at RNSH and 25% to 100% at HKH.
- Errors in medication histories on admission fell by 33% at RNSH and by 44% at HKH with implementation of the intervention.
- Results at both sites clearly indicate that the process is efficacious.

Striving for best practice
- Medication information is set out in a standard unambiguous format providing more thorough and understandable information for all the clinicians involved in the patient’s care.
- This information is easily transferable at each interface of patient care where the potential for error is higher.
- The initiative improves communication between care providers and patients.
- More pharmacy resources were placed at points of admission to hospital.

Innovation
- Good communication within and between sites has lead to a MHAF being agreed for use across all sites in the NSCCHS. This incorporates all aspects of the patient’s medication journey from admission to discharge.
- Workplace redesign showed the effectiveness of an ED pharmacist at HKH.
Application to Other Settings

- The project was effective in both tertiary and district hospitals. Completion of the MHAF allows for flexibility to adapt to local patient populations, working conditions and staffing.
- The findings of our project have been shared with other Australian hospitals to guide development of medication reconciliation projects to reduce medication errors.
Move to Improve: Implementation of a Falls Prevention and Exercise Promotion Program for Patients With Neurological Conditions
Hope Healthcare: Braeside Hospital, Physiotherapy Rehabilitation Day Hospital, Prairiewood, NSW

Author(s)
Belinda Carrasqueira
Mark Buhagiar
Physiotherapists

Aim
To decrease the risk of falls and incident of falls by 80% with the introduction of a targeted falls prevention program, especially for clients with neurological conditions.

Abstract
Falls can result in serious injuries, which inevitably result in poorer quality of life. People with a history of neurological conditions are associated with an increased risk of falls. In the Fairfield district it was identified that a gap existed for falls prevention specifically with this patient population. In 2006, the Move to Improve exercise group was established at Braeside Rehabilitation Day Hospital with the goals of objectively decreasing the incidence of falls by increasing balance, functional mobility and confidence. This 8 week program successfully decreased the incidence of falls by 72%, improve Berg Balance scores on average by 2.2 points and improve Timed Get Up and Go scores by 4.5 seconds.

Application of EQuIP Principles

Consumer focus
- Consumers involved in development of program.
- Participants reported feeling stronger (91%), better balanced (100%), had improved levels of fitness (83%) and walking safer (100%).
- Participants reported highly satisfied with services provided by staff involved.

Effective leadership
- Detailed Orientation and handover process implemented to sustain ongoing success of the group.
- Original team members act as mentors for new therapists.
- Outcomes continue to be monitored to evaluate intervention at end of each cycle
- Permanent RDH meeting agenda item.

Continuous improvement
- Outcomes of the group have been closely monitored and benchmarked against results from research papers.
- The input of the community participants continues to be sought in regards to interest and change.

Outcomes
- Average session attendance was 76.5%.
- Average increase in Berg Balance Scale of 2.2 points.
- Timed Get Up and Go improved an average of 4.5 seconds.
- Activities-specific Balance Confidence scale showed average increase of 5.25 points.
- Intervention group also resulted in a 72% reduction of incidence of falls at 6 month follow up.
**Striving for best practice**

- Evidence sought prior to commencement of group.
- Consumer input sought to meet needs of the community.
- Assistance from peers with information to maximise effectiveness of the program was sought
- Continuous monitoring of outcomes and consumer feedback for further ways to develop the program to best meet needs of community participants.

**Innovation**

- Most falls prevention programs target people at risk of falls with orthopaedic conditions or lifestyle issues in mind. Many exclude people with significant illness and impairments due to lack of ‘commercial viability’ and the high therapist to patient ratio required.
- NSW health directions and best practise guidelines state that all community health services should be exploring avenues to improve efficiency of service in the quest for falls prevention.
- This program targets this particular group of consumers and fills a gap which has been identified in the community.

**Applicability to Other Settings**

- With an ever increasing aging population and better technology, high rates of people are surviving cardiac and vascular events. There is an ever increasing amount of people in the community with neurological conditions resulting in impairment and falls risks.
- The Move to Improve program is a successful example of providing a new falls prevention intervention at no extra cost (therapists and transport provided by pre-existing day hospital program) and could be transferred into other settings with gaps in falls prevention strategies for neurological patients.
Organization Wide Quality Improvement Through Accreditation with Special Focus on Patient, Staff & Visitor Safety
Kerala Institute of Medical Sciences, Trivandrum, Kerala, India

Author(s)
Dr M. I Sahadulla    Chairman & Managing Director
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Mr.Jayakrishnan J    Executive – Health Safety Environment
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All Coordinators & Staff

Aim
Gaining National Accreditation Board for Hospitals & Healthcare Providers (NABH) & Australian Council on healthcare Standards International (ACHSI) accreditation for the hospital by December 2006

Abstract
The ultimate aim of the project was to make KIMS a safer place for patients, visitors and its staff and a world-class center of excellence. Set guidelines by accrediting bodies can aid in standardizing quality & safety initiatives hospital wide. Accreditation will also help legal compliance & promote best practice. System & Process evaluation by external bodies will help Continuous quality improvement and promote proactive approach.

The specific objectives include Implementing a minimum of five Patient Safety Initiatives in the hospital by November 2006, Implementing a minimum of 2 Visitor safety initiatives by September 2006, Implementing a minimum of 5 Staff safety initiates by September 2006 & Implementing Quality Themes & Projects 1 each every quarter. Period of the Project was from September 2006 to December 2006. The project was done through.

Project Plan
1) Self assessment & Gap Analysis
2) Submission of Application:
3) Team Formation
4) Training
5) Policy Formation
6) Quality Projects:
7) Internal Assessment
8) Mock – Survey
9) Final Survey

Implementation & Outcome
1) **Training** given to 1100 staff out of 1200about topics which include Quality, Safety, Infection control, Risk Management, Manual handling, Hazardous chemical handling, Leadership training, Customer Service training, Fire safety, Internal & External Disaster training.
2) 770 policies developed & implemented.
4) **Quality Projects** include Reduce Delay in Discharge Process, Reduce Surgical Site Infection, Reduce Stock-outs in Central Store, To reduce delay in pathology reporting, Visitor Control during visiting hours, Prevention of Decubitus Ulcer.

4) **Staff Safety** – Needle prick reporting system established, reduced height of shelves in Central Stores & Medical Records Department, Fire Safety Training given, Handbooks Quality & Fire Safety issued, Emergency Contact Numbers pasted, Hazardous Chemical cupboards identified, Upgraded fire alarm system to addressable system

**Visitor safety** – Visitor Control, Elevators identified specifically for Patient, Staff & Visitors, Safety Guidelines for patient’s visitors

**Patient Safety** -- ID Bands for patient, vulnerable patient identification *(SAFETY FIRST)*, Hand washing pictures on all areas, Medication Safety Policies, Narcotic Controls instituted.

5) **Mock Drills** – Internal & External Disaster

Outcome
- ACHSI accreditation - January 07
- NABH accreditation - February 07

Application of EQuIP Principles

**Consumer focus**
- Implementation of patient safety and visitor safety measures.
- Quality projects with focus on proper patient care.
- Training on infection control, external & internal disaster.

**Effective leadership**
- Effective participation of all staff from various departments.
- Initiation from the top management.
- Project team – multidisciplinary.
- Decisions by the management to make structural changes.

**Continuous improvement**
- Internal Audit.
- Quality rounds.
- Quality Projects.
- Performance indicators.
- Quality in charges’ meeting.

**Outcomes**
- ACHSI accreditation - January 07.
- NABH accreditation - February 07.

**Striving for best practice**
- Quality themes (In every quarter).
- Six Sigma Projects.
- Open house sessions to generate idea from KIMS employees to improve performance of various day to day activities.
- Interactive sessions.

**Innovation**
- Separate Hazardous Chemical cupboards.
- Addressable fire alarm system.
- ID Bands for patient.
• Vulnerable patient identification stickers (SAFETY FIRST).

Applicability to Other Settings
• Fire Safety Guidelines by the State Government was implemented through the processes.
• Initiated a culture of Quality Improvement in the state (1st & only hospital in India to be accredited by national and international accreditation bodies). Today more & more hospitals are going for national accreditation as well as international accreditations, which improves the delivery of healthcare in India.
Pharmacy Vigilance Minimises the Risks of Medication Adverse Events in the Sutherland Hospital
The Sutherland Hospital, South East Sydney Illawarra Area Health Service, Caringbah, NSW

Author(s)
Caroline Zeitoun  Director of Pharmacy
Gerrie Goossens  Patient Safety Manager

Aim
The aim is to ensure continuous patient medication safety.

Abstract
In 2004 the NSW Minister Of Health launched the NSW Patient Safety and Clinical Quality Program (PSCQP). The implementation of the electronic Incident Information Management System (IIMS) was a key component of this. It was established as a system of notification of all incidents whether they were clinical or non-clinical, actual or ‘near miss’.

Analysis of the first year of IIMS Data in the Annual Report 2005-2006 produced by the Clinical Excellence Commission indicates that the administration of medications accounts for 37% of the total medication incidents reported with prescribing incidents coming in second. This pattern is significantly reversed at TSH.

The ‘roll out’ of IIMS at TSH in March 2005, identified that pharmacists were already identifying, correcting and recording medication ‘prescribing’ errors. As the IIMS system was introduced throughout the Hospital, the Pharmacy interventions were entered into IIMS as an electronic record of ‘near miss’ incidents.

From March 2005 until April 2007, TSH has reported 1762 medication incidents of which 1261(72%) are prescribing errors compared to 172 (10%) administration errors. The Pharmacy Department has been responsible for the reporting of 76% of medication incidents during this time frame.

These reported Pharmacy incidents are actually ‘near miss’ interventions significantly reducing the number of medication ‘administration’ incidents on this campus.

Application of EQuIP Principles

Customer focus
- The pharmacist identifies a problem, the respective medical officer is contacted immediately to correct the error.
- The resolved problem is entered into IIMS as a clinical incident.
- Two ‘monthly’ reports are generated from the system. One is a ‘Select ‘Medication Report identifying the prescriber of the errors and the second report, which is de-identified and tabled at the Drug and Therapeutics Committee and the monthly Medication Incident Review Committee.
- The data collected is tabled monthly by the Pharmacy Department as commonly prescribed errors.
- The data is published in the two monthly Drug Bulletin produced and circulated from the Pharmacy Department. The Drug Bulletin is sent electronically to all medical and nursing staff across the Organisation and hard copies are distributed in clinical ward areas.
**Effective leadership**
The IIMS ‘Select’ Medication Report is circulated electronically to the Director of Clinical Services (DCS) and the Director of Clinical Training (DCT) - JMO Management. The ‘Select’ Report together with the Common Prescribing Errors Report generated by Pharmacy are used by the DCT as a performance management tool for prescribers that require extra supervision and direction.

**Continuous improvement**
The effectiveness of the clinical Pharmacy Service is measured by using the NSW Therapeutics Advisory Group Clinical Indicator 7.2 ‘Percentage of Pharmacist Recommendations Resulting in a Change Of Therapy’.

**Outcomes**
This indicator is measured each quarter and consistently shows that over 90% of all pharmacist recommendations result in a change of therapy. This highlights the pharmacist's important role in quality use of medicine and patient care.

**Striving for best practice**
The Clinical Excellence Commission Report, -Analysis of First Year of IIMS Data, Annual Report 2005-2006, depicts that the majority of medication incidents are administration incidents as opposed to prescribing incidents. TSH data depicts the opposite trend largely due to Pharmacy interventions resulting in ‘near miss’ incidents. This highlights how pharmacists are playing a significant role in the risk management of potential medication incidents.

**Applicability to Other Settings**
Medication safety is one of the most important issues facing the healthcare system. Any system set up to risk manage and minimise adverse effects on patients should be adopted in other health care settings.
PICC Us – Venous Access Team  
Hunter New England Health, Manning Rural Referral Hospital, Taree, NSW

Author  
Melissa Robinson-Reilly Clinical Nurse Consultant / Registered Nurse - Oncology

Aim  
To reduce cannulations on venously challenged patients through appropriate assessment of intravenous requirements, to improve hospital experience, to reduce infection risk, and to ensure efficacy and cost effectiveness.

Abstract  
The skills gained by Oncology nurses in venous access are well defined. At the Manning Rural Referral Hospital, Taree, two Oncology Clinical Nurse Consultants have branched out, expanded their role by formalising their clinical skills into a Venous Access Team (VATeam). Supported by the hospital’s Intensivists, Director of Nursing and General Manager, presented a case study to highlight the need for an intervention team, thus VATeam formalised in February 2006. The VATeam strives to benchmark a service in this rural area, to equate metropolitan health services. The use of Peripherally Inserted Central Catheters is a minimizing invasive option for administrating chemotherapy and irritating medications. In 2002, 2 PICC lines were inserted and in 2005, only 44.

Aim: Historical issues surrounding PICCs, included recognition of the venous access skills of nurses, the premature removal of lines, and the poor identification of venous requirements. The VATeam aims to reduce the frequency of cannulations in venously challenged patients, improve the patient experience, reduce infection risks, and be a totally nurse-driven patient intervention.

Method: Through education sessions across nursing/medical arena, in-hospital referral has increased, with 100 PICCs inserted February - December 2006 with zero infection indicated by PICC lines inserted by the CNCs. The costing comparison is evidenced based; comparing cannulae, bed days Vs PICC, staff time, affirmed from in-house data collected.

Conclusion: The future continues with the introduction of an information brochure for patients before consent, on-ward PICC troubleshoot checklist, RN x-ray competency, ultrasound placement of PICCs, and onsite PICC Insertion Workshop to recruit Registered Nurses into the VATeam. The longevity of the VATeam is dependant on being a ‘stand alone’ rural service.

Application of EQuIP Principles

Customer focus
- 1.1.1 the assessment ensures current and ongoing needs of the consumer/patient are identified. The aim of the VATeam is to ensure that patient care is a priority and that appropriate decision-making includes venous assessment.
- 1.1.2 care is planned and delivered in partnership with the consumer/patient and when relevant, the carer, to achieve the best possible outcome. This aligns to early discharge; prompting a service from a patient perspective, with support from the community base ambulatory care team to continue intravenous antibiotic therapy in the home rather than a prolonged hospitalisation.

Effective leadership
- 1.1.2 aligns with inspiring and motivating Registered Nurses to be innovative and creative, to contribute to the delivering of optimum management of PICCs. Learning through 1-day workshop that capacity builds skill and recruitment of nurses into the VATeam.
The CNCs have provided direction for Manning and represented at local, national, and international levels.

**Continuous improvement**
- 1.1.4 care is evaluated by health care providers and when appropriate with consumer/patient and carer. The VATeam is constantly looking for ways to improve an often-essential service through patient story and education across Nursing and Medial teams. Data collection evidences that care can be consistently met.
- 1.1.3 patients are informed of the consent process understand and provide consent for their healthcare, with the support of an information brochure about PICC line insertion before consent. This address, reason for insertion, risks, and expected complications.

**Outcomes**
- 1.1.1 aligns with data collection from PICC insertion, such as, dwell time of the PICC, whether discharged to a community-based program, and the number of patients referred for the procedure.
- 1.1.4 and 1.1.5 is met through appropriate discharge/transfer addressing the needs of the patient.
- 1.5.2 the infection control system supports safe practice with an intervention specific team, with data that indicated zero infection rate from CNC insertion technique.
- Improved operational performance with the recruitment of 2 Registered Nurses to trained in PICC insertion.

**Striving for best practice**
- 1.1.8 documentation and accurate recorded information in medical record post procedure provides type of device used, indwelling length, external length, PICC tip placement confirmed by chest x-ray, and follow up procedures.
- From a corporate perspective, 2.1.1, the CNCs have provided Manning with continuous quality improvement system, and with the support of the hospital commits to improve outcomes of care and service delivery.
- Promulgating achievements at peer conferences and in publication.

**Innovation**
- Rural Nurse Intervention – Venous Access Team.
- Presented innovation to peer conferences in Tamworth, Brisbane, Melbourne and Christchurch NZ.
- Published in the Australia Nursing Journal.
- Preparation for a business case with the evidence to sustain a stand-alone intervention service.

**Applicability to Other Settings**
- The rural nurse specific intervention promotes nurses to review their individual scope of practice.
- Role diversity and skill is an outcome of this intervention that can be shared and promoted across the nursing arena.

Feedback from a committee member of the NZ Intravenous Nursing Group intimated possible return to support nurses in rural NZ in developing similar practice.
Post-Seclusion Counselling (PSC): A Therapeutic Intervention
Southern Health, Quality Unit, Clayton South, VIC

Author
Dr Lillian Nejad  Clinical Psychologist

Aim
To diminish the potential negative short-term and long-term consequences of seclusion and to prevent future seclusion episodes for inpatients in psychiatric wards

Abstract
While there is a worldwide trend toward the reduction, and even elimination, of seclusion practices in psychiatric inpatient units, it continues to be a common practice in Australia. Research has shown the use of seclusion in psychiatric inpatient units is often associated with problems such as loss of therapeutic rapport between patients and nurses and potential negative psychological consequences for the patient. Despite these inherent problems, there is a dearth of specific programs that assist patients after a seclusion experience. To try and address this gap in mental health services, two psychologists developed a therapeutic intervention, “Post-seclusion counselling (PSC)” that aims to reduce the chance of negative psychosocial problems for patients as well as to prevent further seclusion episodes.

As part of a pilot project commenced in 2002, a workshop was developed that psychiatric nurses from two inpatient units volunteered to attend. The workshop aims to raise awareness of the problems associated with seclusion, to allow participants to discuss their difficulties associated with seclusion, and to introduce PSC and the benefits associated with ensuring that all inpatients who have experienced seclusion are given the opportunity to talk about how they felt, to clarify aspects of the seclusion episode, and to discuss how to prevent further seclusion episodes.

Results from baseline data showed that post-PSC patients had a more accurate and more integrated understanding of the seclusion episode in comparison to baseline data. All but one patient reported that PSC was helpful. Transfer of training data was also gathered to assess the benefits and barriers nurses perceived in providing PSC. Results showed nurses believed PSC was an important intervention that was benefiting their patients and reported providing the intervention to more than 40 patients, although this was not formally documented in the patients’ casenotes.

Application of EQuIP Principles

Customer focus
- A gap identified in services for seclusion inpatients.
- Inpatients were asked about their seclusion experiences.
- Literature review on inpatients’ seclusion experiences and consequences.
- Consumer consultants were involved through staff focus groups.
- Aim of intervention to improve services for inpatients and prevent further seclusion episodes.

Effective leadership
- Multi-disciplinary and multi-level consultation and collaboration (NUMs, psychiatrists, psychologists, consumer consultants) in implementing project.
- Development of intervention based on literature review and clinical knowledge.
- Facilitation of workshops for nursing staff across two inpatient psychiatric units, consumer consultants have also attended workshops.
Presentation of intervention and results at TheMHS conference in 2003.
Presentation of intervention and results to Chief Psychiatrist in 2003.
Presentation of intervention and results to NUMs statewide at Chief Psychiatrist’s office in 2005.
PSC Train the Trainer Manual developed and requested by several hospital inpatient NUMs.
Involvement in Seclusion project working party at Dandenong.

Continuous improvement
- Working with Chief Psychiatrist’s office to incorporate PSC into training to help reduce seclusion rates in psychiatric inpatient units in Victoria.
- Workshops continue to be offered to staff and are updated and improved according to participants’ evaluation results.
- Offered workshops to continuing care staff e.g. RAPPS (Early psychosis team) so they may provide PSC if not given on the ward.

Striving for best practice
- Clients have the right to be treated with respect and dignity in a safe, humane, culturally sensitive and developmentally appropriate manner that respects client choice and maximises self-determination.” APNA, 2001
- There is a general worldwide trend towards the reduction of seclusion practices; however, it is still very much a part of the reality of psychiatric inpatient units in Australia. It is therefore important to attempt to moderate the negative effects of these practices.
- Publications have reported significant reductions (70-94%) in seclusion rates following programmatic changes which included structured sessions post-seclusion (Busch, 2000; Taxis, 2002).
- The focus was to ensure psychological needs of patients post-seclusion were met.
- Project highlighted that documentation in relation to pre, during and post-seclusion practices was not sufficient and need improvement.

Innovation
Although the literature stated structured post-seclusion sessions were helpful, they did not specify the process or content of these sessions. The intervention, handouts and workshop was fully developed by two clinical psychologists based on their literature review and their clinical knowledge and experience. They were supported by the psychology department, NUMs and other multi-disciplinary staff who were consulted regularly.

Applicability to Other Settings
- The intervention is applicable to all psychiatric inpatient units who use seclusion practices. Several other public hospitals have requested the PSC Manual for staff training.
- Aspects of the intervention would also be useful to continuing care staff in mental health for patients with difficulties due to past seclusion experiences.
- The intervention may also be useful to other medical departments when seclusion or restraint practices are utilised e.g. emergency departments.
Pre-Admission of the Joint Replacement Patient
Warringal Private Hospital, Nursing, Heidelberg, VIC

Author(s)
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Karen Guy   Orthopaedic Surgical Case Manager

Aim
The aim of the new pre-admission/prehabilitation process is to provide a group forum for patients undergoing total joint replacement, which prepares them for hospital admission and encourages them to participate in an exercise/prehabilitation program which aims to achieve optimal outcomes post surgery.

Abstract
Warringal Private Hospital (Warringal) has four specialty case managers who are responsible for the pre-admission/risk assessment of patients, the facilitation of discharge planning and the management of length of stay. The pre-admission of orthopaedic patients was introduced at Warringal in 1995. The pre-admission of patients is important as risks can be identified prior to admission, discharge planning can be commenced and education for patients on their procedure can be provided. On average around 600 joint replacement patients are pre-admitted each year by the orthopaedic case manager.

The pre-admission process for joint replacement patients has been refined and altered over the years to suit customer and organisational requirements. Until March 2006 patients attended a group physiotherapy session at Warringal, the class size of this group was small due to limitations in available space. This session was held approximately two weeks prior to surgery and then patients had a pre-admission interview with the case manager. The pre-admission interview was taking between 30 – 40 minutes and given the numbers of patients that had to be pre-admitted it was time consuming and repetitive.

Observation was made that patients coming in for surgery in January /February 2006, who had attended their physiotherapy class in December 2005 appeared to have increased mobility and movement post operatively. It was thought that this was due to the fact that these patients had a longer time, up to six weeks pre-operatively, to practice their exercises prior to surgery.

This anecdotal evidence that giving patients more time to practice exercises pre-operatively aided post operative recovery, along with the fact that the pre-admission interview was time consuming and repetitive prompted a review of the pre-admission/prehabilitation process for patients undergoing total joint replacement.

Following discussion with Surgeons, Physiotherapists, Case Manager and Nurse Unit Manager it was decided to introduce a new pre-operative/prehabilitation information session that would be held 4-6 weeks pre-operatively. This session would be followed up with a 10 -15 minute phone call by the case manager. The sessions are held off site enabling up to 12 patients per class to attend and were introduced in March 2006.

In conjunction with the new information session comprehensive patient information booklets were developed and introduced. Good outcomes from these sessions have been achieved. Patients have indicated through satisfaction surveys that they enjoy the program and 100% state that the session prepared them for their hospital stay. The majority of patients who attend the sessions are booking in at least 4 weeks prior to surgery. There has been a decrease in length of stay for both total hip replacement and total knee replacement patient, with no increase in the ACHS clinical indicators of return to the operating room or readmission to hospital.
Application of EQuIP Principles

Outcomes
- Length of stay has decreased for both total knee and total hip replacement patients.
- Rates of Return to OR and Readmission to Hospital both ACHS clinical Indicators have not increased since the program was introduced.
- More appropriate use of the orthopaedic case managers’ time.
- 100% of patients stated the group session prepared them for their hospital stay.
- The majority of patients are booking into the program at least 4 weeks prior to admission.

Customer focus
- All stakeholders were involved in reviewing the pre-admission process and it was endorsed by all the orthopaedic surgeons conducting joint replacements at Warringal.
- Consumers have been surveyed as to their impressions of the new process. Patients have stated that they enjoy the session as it gives them a sense of not being alone, feeling prepared for their hospital stay and they enjoyed the session.
- The information booklets given to patients can be utilised as a learning tool for new staff to the orthopaedic unit at Warringal.

Leadership
- The program has improved resource allocation for the orthopaedic case manager and the program has the full support of the executive team at Warringal.
- The Orthopaedic Case manager has been asked to present the pre-operative/prehabilitation information program to the Victorian Orthopaedic Nurses Association Meeting in August 2007.

Continuous improvement
- Models have been sourced from Stryker and these are used at the information session to explain the anatomy and show the patients what their operation will entail.
- Staff involved in the program are constantly updating the information given to patients to ensure it is relevant and accurate.
- The new patient information brochures are comprehensive and cover all aspects of care.

Striving for best practice
- Information is continually reviewed to ensure best practice. Research indicates that the number of hip and knee joint replacements in the private sector is increasing at a higher rate than in the public sector.
- Programs that address the enhancement of functional activity pre-operatively to aid and accelerate post operative recovery are highly recommended.
- Research indicates that the patient who has prehabilitation has a higher level of functional ability post-operatively.

Innovation
This concept is not new; many organisations have group pre-operative information sessions and exercise classes for joint replacement patients. When Warringal was reviewing programs prior to the introduction of this one, there were not many programs that had such an advanced component of exercise prehabilitation.

Applicability to Other Settings
The principles behind this project are very readily transferable to other health care organisations.
Preventing Surgical Site Infections in Maternity- A Collaborative Approach
Hornsby & Ku-Ring-Gai Health Service, Women's Childrens Family / Surgery & Anaesthetics, Hornsby, NSW

Author(s)
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Janice Sim
Carol Reidy
Jane Waldron
Dr John Keogh

Aim
To decrease the incidence of surgical site infections in LSCS patients thus preventing fatal and non-fatal harm and achieve 100% compliance with the four components of the Preventing SSI bundle.

Abstract
As part of the SSSL project at Hornsby Ku-ring-gai Hospital, recommendations were made to focus the SSI bundle of care on, the Lower Segment Caesarian Section (LSCS) population. Current literature research has shown that postoperative infection can be up to 30% following a LSCS. Prior to the start of this project, post operative LSCS infections at HKH have been measured at 20% (O'Mahony). This project was in collaboration with Maternity, Operating Theatres and Infection Control.

Methodology
A Quality Assurance audit/Ethical review application was completed for this project. The project was colour-coded orange for heightened staff awareness. The Project Team met regularly during the project and reviewed current practice. Results were compared with SSSL SSI bundle components. Gaps were identified and audit tools developed with input from key stakeholders to facilitate compliance monitoring and highlight the practice changes. The audit tools were completed by Maternity, Operating theatre (OT) staff and the project officer.

All patients undergoing LSCS were included in the project. Data was collected by using retrospective medical records audits and post-discharge surveillance.

The key Interventions of SSI Bundle for this project were:
1. Day of Surgery Admission
2. Appropriate use of prophylactic antibiotics
3. Appropriate hair removal
4. Compliant with local surgical wound care protocol

Application of EQuIP Principles

Customer focus
- An information pamphlet called ‘Are you having a Caesarean Section?’ was developed.
- In addition Women received pre-operative skin care education in Day Assessment Unit and at their 36 week antenatal visit.
- A brief project description and privacy information letter was written given to all patients post LSCS.
- A bonus of this project is that all women undergoing LSCS will have uniform education and information regarding their pre operative, intraoperative and post operative care.
Effective leadership
A collaborative approach amongst key departments was fostered to implement the components of Safer System Saving Lives4 (SSL) SSI bundle. The project team addressed gaps such as: education in pre-operative skin care, appropriate use of prophylactic antibiotics in operating theatre, appropriate and timely hair removal and compliance with a locally developed surgical wound care protocol.

Continuous improvement
- All components of the SSI project have been sustained since the project finalised in February 2007.
- The Division of Women’s Children and Family services hope to sustain surveillance by appointing a Quality Resource Nurse to continue to monitor compliance.
- The education of all women undergoing LSCS will be sustained by the continued distribution of the information pamphlet.

Outcomes
There has been a statistically significant improvement in patient outcomes with the implementation of the entire SSSL SSI care bundle. From baseline audits where the average infection rate was 20% it decreased to an average of 11% by the end of November when the final bundle component was introduced. Currently the data indicates an infection rate of zero.

Striving for best practice
- In 2003 the Australian Council for Safety and Quality in Health Care suggested that the incidence of SSI nationally is between 2-13%.
- Current literature reviews have shown that postoperative infection can be up to 30% following a LSCS.
- At Hornsby Ku-ring-gai Hospital (HKH) baseline data for women undergoing Lower Segment Caesarian Section (LSCS) suggests that post operative infections were as high as 20%.

Innovation
- The project relates to the strategic directions of NSW Health: “make prevention everyone’s business”.
- The project build bonds between three major disciplines Maternity, Operating Theatres and Infection Control. The processes utilised in this project could be implemented for other surgical procedures.

Applicability to Other Settings
With a collaborative approach the potential for preventing and or minimising adverse outcomes in patient undergoing surgery is within reach.
Promoting Clinical Excellence in Palliative Care on Brisbane’s Southside
QEII Hospital Health Service District, Brisbane South Community Health Service, Acacia Ridge, QLD

Author(s)
Pat Matthews    Executive Officer Brisbane South Community Health Service
Elizabeth Reymond  Clinical Director Brisbane South Palliative Care Service

Aim
The aim of the Brisbane South Palliative Care Collaborative is to improve the provision of services to, and outcomes for palliative clients and their carers

Abstract
The Brisbane South Palliative Care Collaborative (BSPCC) represents a joint partnership between three complementary institutions; Queensland Health via Brisbane South Community Health, Palliative Care Service, the School of Medicine Griffith University, and Mt Olivet Palliative Care Services, Sisters of Charity. This service-based partnership was established in March 2005 with initial funding for two years. The purpose of the BSPCC is to progress best practice clinical palliative care service delivery across Brisbane South and surrounds, by implementing quality improvement programmes, delivering evidence-based palliative care education and training, and developing intersectoral palliative care research projects aimed at improving symptom control for palliative patients. Significant outcomes have been achieved, resulting in an agreement to continue the joint funding arrangement and collaborative for a further 2 years at least. The overall aim of the BSPC is to facilitate best practice in Palliative Care.

Application of EQuIP Principles

Customer focus
Several of the projects undertaken have specifically identifying available services, service gaps and needs for the entire “customer” target group (staff, clients and carers). Recommendations have been made and implemented in order to resolve identified needs and gaps (see outcomes in main report)

Effective leadership
• Executive Management in all three partner organisations have assisted the leadership and achievements of this collaborative and are represented on the steering committee.
• The collaborative is linked with Queensland Health (Southern Health Service Area) Palliative Care Clinical Network, leading and influencing Queensland health’s policy direction in Palliative Care service provision.

Continuous improvement
• Works collaboratively, undertaking research and evaluating client services across in-patient and community sectors.
• Initiatives and recommendations are based on best practice evidence to improve the quality of palliative care at local, state, national and international levels.
• The collaborative undertakes a wide range of research and project activity which contributes to the evidence and improved outcomes for Palliative clients and carers.
Outcomes
A wide range of outcomes have been achieved, these are listed more fully in the main report, but in summary they can be split into:

- Clinical Research: 8 studies
- Education – delivery / resources: 10
- Service Provision/Mapping projects: 5
- Conference Presentations: 16
- Papers / Publications: 4 (peer reviewed)
- Reports: 6

Striving for best practice
The BSPCC charter is to achieve best practice in the delivery of Palliative Care services. Outcomes to date illustrate significant achievement in this area.

Innovation
- The idea of a cross-organisational collaborative with a specific service delivery focus is innovative in itself.
- Service initiatives driven by BSPCC have resulted in increased service capacity for all palliative care organisations in South East Queensland.

Applicability to Other Settings
BSPCC has provided a template for the establishment of other partnerships in targeted service delivery areas. The model is easily able to be generalised.
Reduce Delay in Issue Time of Discharge Summary
Kerala Institute of Medical Sciences, Trivandrum, Kerala, India

Author(s)
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Aim
To reduce the discharge summary issue time to less than 3 hours for all departments.

Abstract
The project aims to improve patient satisfaction by reducing the discharge summary issue time (The time when the nursing station informs the Department of Medical Transcription till the issue of ‘discharge summary’ to the nursing station was taken for the study) to less than 3 hours for all departments through effective and systematic methods, which in turn will help the organization to meet its quality objectives. As Patient Counselor got remarks from patients about the delay in getting Discharge Summary, the Department of Medical Transcription analyzed and compared the Discharge Summary Issue time of various departments. From that it was observed that most of the departments are taking more than 6 hours to issue discharge summary, which causes many difficulties for the patient. So a project was undertaken (Period – 4Months) with the main objective of reducing delay in Discharge Summary Issue Time. The Department of Medical Transcription handles the issuing of Medical Certificates, Discharge Summary Report, Angiogram report and Referring letters. The department receives online and handwritten summary from clinicians.

Data Collection
Primary data collected from Discharge Summary detail sheet and direct feedback from patients to Patient Counselor during daily rounds. Population was the total number of discharges/month (July 2006 – 1504, October 2006 - 1480). The departments taken for the project include General Surgery, Gynaecology, Internal Medicine, Neurology, Neurosurgery, Orthopaedics, Paediatric Surgery, Paediatrics/Neonatology & Plastic Surgery.

Initial study showed that departments take more than 4 hours to issue discharge Summary include General Surgery, Orthopedics, Internal Medicine, Gynaecology & Pediatrics/Neonatology.

How did the team go about their task, how long did they take

• Project team did a brain storming session.
• Prepared cause and effect diagram & Fishbone (Ishikawa) diagram.
• Prepared a detailed process flow chart.
• Identified data measurement points.

Problems Identified
• Lack of discharge planning.
• Underutilization of Online Discharge Summary.
• Consultant writing the discharge summary only after their outpatient clinic time.
• Draft summary sent again to consultant in OP for correction.
• Delay in indenting the Discharge Medicine.
• Lack of option to copy lab reports – Time lost in keying in the reports again.
Implementation & Evaluation
- Discharge planning initiated.
- Online discharge summary initiated.
- The statistics was shown in Doctor’s meeting, so that they realize the actual picture and difficulty faced by the staff.
- All Discharges taking more than 4 hours were reported to Management for action.

Outcome
- The average time taken of discharge is higher while taking the project and it was about more than 6 hours. Here it shows remarkable improvement in majority of the departments.
- The Departments with maximum average discharge Summary issue time were General surgery & Orthopaedics for which the time shows a significant reduction.
- Average discharge time decreased from 6 hrs (July 06) to 3 hrs (Oct 06).
- Complaints regarding delay in discharge are immensely reduced after taking it as project. This shows that the patient satisfaction has increased.

Application of EQuIP Principles

Consumer focus
- The objective was to reduce delay.
- Improve patient satisfaction by reducing waiting time after discharge.

Effective leadership
- Effective participation of staff from various departments (Department of medical Transcription, nursing, doctors, Quality Systems, Information Technology & Safety Department).
- Brainstorming sessions.
- Project team – multidisciplinary (Pathologist, technicians, Quality personnel & surgeons).
- Discussion about statistics in monthly Doctor’s meeting.

Continuous improvement
- Monthly Performance indicator on delay in discharge summary issue time.
- Discharge planning form initiated and compliance to the same is monitored.

Outcomes
- Discharge summary issue time reduced from 6 hours to 3 hours.
- Significant decrease in the patient’s complaints counselor regarding discharge delay (41% in June 06 to 5% in November 06).
- Waiting time of patients after discharge reduced.

Striving for best practice
- Software reformation and less errors.
- Introduction of Electronic medical Records.

Innovation
- Discharge planning form for doctors and nurses.
- Online summary with the help of existing telephone lines through 2 dedicated lines.

Applicability to Other Settings
- Availability of Online data helped other departments like Insurance Desk for report submission to authorized personnel.
- Doctors started using Electronic Medical Records more frequently.
- Errors in discharge summary came down due to online corrections.
Reducing Amiodarone-Induced Thrombophlebitis
Sir Charles Gairdner Hospital, Coronary Care Unit, Nedlands, WA

Author(s)
Deborah Wilson
Justine Burg
Cheryl Blanton

Aim
To determine the causative factors of Amiodarone-induced thrombophlebitis and identify measures to minimise any future cases.

Abstract
The incidence of amiodarone-induced thrombophlebitis prior to March 2006 within the Coronary Care Unit (CCU) was nil, although the literature suggests an incidence of 2-8%. Three episodes were noted on incident report forms between March and July 2006. With the possible negative effects on patients, CCU nursing staff sought to identify the causative factors of this increased incidence and to minimise any future cases of thrombophlebitis. For a one month period, August 2006, all patients (n=140) with Intravenous (IV) cannulae/infusion (n=227) were assessed and data was collected regarding cannula site, who inserted, infusions, days insitu and indications for cannula removal. During the first week of the study seven cases of thrombophlebitis were identified and all cases (100%) were receiving IV amiodarone either alone or in combination. It was then identified that a different commercial provider of IV Amiodarone was introduced to Sir Charles Gairdner Hospital (SCGH) in June 2006. The CCU changed back to the original commercial provider of IV Amiodarone prior to June 2006, with nil incidence of amiodarone-induced thrombophlebitis from CCU delivered infusions, however two further incidences of thrombophlebitis did occur within the CCU. In these patients IV amiodarone was initiated from either another area within SCGH or another hospital. Other criteria identified as possible causes of mild to moderate phlebitis included IV site choice with a marked increase to antecubital fossa site (15/30, 50%) and IV inserted at other hospitals under emergent conditions (11/30, 37%). After consultation with SCGH Clinical Governance Unit, the commercial provider of the IV Amiodarone, Executive Director of SCGH and other hospitals in Western Australia, the recommendation was to remove the stock of the Amiodarone introduced in June 2006, not just from CCU, but from the entire hospital, including the emergency trolleys. A secondary recommendation was for the changing of IV cannula which are inserted at other hospitals, as they correlated highly with minor to moderate phlebitis. During the follow-up period, amiodarone-induced phlebitis was recorded in 8% of patients within CCU and in all of these cases the IV was inserted under emergent conditions. There were no incidences of amiodarone-induced thrombophlebitis

Application of EQuIP Principles

Customer focus
The occurrence of Amiodarone-Induced Thrombophlebitis caused negative effects on CCU patients such as the:

- Development of severe pain and discomfort from affected IV cannula pathway.
- Development of large areas of altered skin integrity as the thrombophlebitis caused patients to develop 10cm X 10cm areas of redness with erythema and swelling from affected IV cannula pathway.
- Commencement of IV antibiotic therapy.
- Need for an increased length of stay in hospital as procedures and surgery that were required had to be delayed.
**Effective leadership**

- All CCU nursing staff were proactive in the reporting of incidences of thrombophlebitis using Clinical Incident Forms, which are part of the Advanced Incident Management System (AIMS) utilised at SCGH.
- Investigation of the AIMS forms by the senior CCU nurse ensured recommendations were made and actions taken including:
  - Providing details to the relevant authority via the SCGH’s Clinical Governance Unit, i.e., the notification of the Adverse Drug Reactions Advisory Committee.
  - Notification of the drug company of the occurrence of adverse events relating to the administration of IV Amiodarone.
  - Escalation of incidents to Nurse Co-director of Heart and Lung CSU and Executive Director of SCGH. Upon being informed, the stock of Amiodarone was removed from the SCGH, including hospital resuscitation trolleys.
  - Informing other hospitals within Western Australia by the hospital executive of the incidents.

**Continuous improvement**

- Six monthly quality reviews of IV cannula/infusion within CCU where nursing staff collect and analyse data before providing feedback during a CCU meeting.
- Continuous observation of patients receiving IV Amiodarone infusions for adverse events by CCU nursing staff.
- Ongoing review of completed AIMS forms if a patient requires the removal and resiting of an IV cannula by the senior CCU nurse to determine causative factors.

**Outcomes**

- Nil further cases of Amiodarone-induced thrombophlebitis as evidenced by follow-up data which equates to the absence of:
  - Patient pain and discomfort.
  - Need for antibiotic therapy.
  - An increased length of stay.
  - Delayed procedures and surgery.

**Striving for best practice**

- The Quality Improvement Project Reducing Amiodarone-Induced thrombophlebitis has led to all CCU nursing staff taking a proactive approach to quality improvement and demonstrates their willingness to be involved in routine monitoring, the reporting of incidents and adverse events and demonstrates an enthusiasm in seeking innovative solutions.
- Ongoing monitoring to determine that if amiodarone-induced thrombophlebitis does occur in the future within CCU that it is within the published thresholds.

**Innovation**

Initiation of this quality improvement project has received local recognition by being the recipient of the 2007 Patient Safety Award for quality improvements in Medication Safety from the Office of Safety and Quality in Western Australia.

**Applicability to Other Settings**

This quality improvement project identifies a problem that has the potential to be seen in other hospitals and with the leadership role taken by this organisation, notification of relevant authorities has occurred.
Reducing Central Venous Catheter related Bloodstream Infections in a Paediatric Intensive Care Unit
The Children’s Hospital at Westmead, Service Improvement Unit, Westmead, NSW

Author(s)
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Ahmed Jamal   CPI Co-ordinator, SIU
Elizabeth Harnett  Service Improvement Co-ordinator

Aim
The aim of the project was to reduce central venous catheter related bloodstream infections (CVC-BSI) in the Paediatric Intensive Care Unit at CHW from the baseline of 9.0 infections per 1000 catheter days.

Abstract
Central Venous Catheter related bloodstream infections (CVC-BSI) are a significant problem in the healthcare setting. This is not only in terms of: the frequency of their occurrence, but also the financial, and importantly the human costs of increased morbidity and mortality.

The Children’s Hospital at Westmead (CHW) was the only paediatric hospital in Australia chosen to participate in the Safer Systems Saving Lives collaborative project. The ‘bundles of care’ interventions, recommended as part of the CVC-BSI aspect of the collaboration, were modified by a local project team to suit local Paediatric Intensive Care Unit (PICU) conditions. The project team comprised staff from the PICU, Service Improvement Unit (SIU) and microbiology staff.

A number of interventions were implemented and compliance with required interventions was measured.
- **Intervention 1:** Introduction of a dedicated central venous line insertion trolley.
- **Intervention 2:** Implementation of education for PICU registrars and nursing staff to increase awareness of infection control requirements regarding CVC insertion, maintenance, as well as appropriate removal.
- **Intervention 3:** Implementation of observance of maximal barrier precautions
- **Intervention 4:** Use of 2% chlorhexidine in 70% alcohol for cleansing of CVC insertion site.
- **Intervention 5:** Strict hand hygiene observance.
- **Intervention 6:** Requirement for completion of a CVC insertion audit tool.
- **Intervention 7:** Daily review of central line necessity.

Whilst we had numerous process measures, our overall outcome measure was the actual rate of infection over the course of 12 months. The CVC-BSI rate for patients in the PICU at the Children’s Hospital at Westmead prior to the commencement of the project initiatives was 9.0 infections per 1,000 catheter days. The project has been very successful with the CVC-BSI rate reduced to 5.66 infections per 1,000 catheter days.

Application of EQuIP Principles

*Customer focus*
Although there was no direct pressure from the consumers to reduce the CVC related Blood Stream infection rate, the main impetus for the project was to meet consumer expectation of provision of safe care by the hospital especially in the intensive care unit.
Effective leadership
The hospital realises that sustainable change requires leadership at all levels of an organisation. Each layer or level plays a different but significantly important role in improving the quality and safety of the care delivered by the hospital. Therefore a project team consisting of PICU, Microbiology, Infection Control, and SIU staff was set up to plan and implement the interventions. As the only children's hospital in Australia taking part in the collaborative, a leadership role was taken on by the team in order to ensure that a successful project, relevant to the paediatric setting, was implemented.

Continuous improvement
A continuous improvement approach was adopted to progress the project. Measures and a baseline were established for improving the outcomes, interventions were planned and implemented, measures were regularly monitored, barriers were identified and addressed, leadership and stakeholders were engaged, regular feedback on progress was provided to the management and stakeholders. The results clearly demonstrate an improvement in outcomes.

Outcomes
A baseline for CVC-BSI of 9.0 infections per 1000 catheter days was established by using retrospective data for eight months (October 05 – May 06). Data collected since the commencement of the project (June 06 to April 07) reveals an average of 5.66 infections per 1000 catheter days. This is a significant 40% reduction in infection rates. The attached graph represents the CVC-BSI trend for the baseline and the project period.

Striving for best practice
Various resources; primarily overseas PICU CVC-BSI projects and literature were consulted and used to inform the interventions implemented.

Applicability to Other Settings
CVCs are maintained and/or inserted in other areas of the hospital and other paediatric hospital populations. Patients with CVCs in these settings are also vulnerable to obtaining BSIs with associated increased financial and personal costs.
Reducing Hospitalwide Methicillin-resistant Staphylococcus Aureus (MRSA)
The Alfred Hospital, Bayside Health, Infection Control, Prahran, VIC

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Aim
To determine whether limited interventions would lead to a reduction in MRSA hence improving outcomes for patients.

Abstract
A series of interventions were implemented over time to reduce MRSA at the Alfred hospital. The Alfred hospital is a 420 bed major tertiary referral hospital with a 35 bed intensive care unit. The interventions commenced in January 2003 in the Intensive Care Unit because patients in these areas are considered to be at high risk of acquiring MRSA. The first two interventions introduced into the Intensive Care Unit were a gel based hand hygiene product and an ‘antibiotic resistant organism’ sign for anyone found to be harbouring MRSA.

In June 2004 a hospitalwide MRSA feedback program utilising annotated Statistical Process Control charts commenced. On a monthly basis all fifteen hospital wards and intensive care received their own ward MRSA Statistical Process Control chart and the hospitalwide Statistical Process Control chart.

The rate of new MRSA patients in intensive care in the intervention period was 6.7 per 100 patient admissions 95%CI(5.2-8.5) compared with 9.3 per 100 patient admissions 95%CI(7.5-11.2) in the pre-intervention period (P = 0.047).

The rate of new MRSA patients hospitalwide (including intensive care) in the intervention period was 1.7 per 100 patient admissions 95%CI(1.6-1.8) compared with 3.0 per 100 patient admissions 95%CI(2.8-3.2) in the pre-intervention period (P < 0.001).

The rate of MRSA bloodstream infections hospitalwide (including intensive care) in the intervention period was 0.27 per 100 patient admissions 95%CI(0.24-0.32) compared with 0.45 per 100 patient admissions 95%CI(0.38-0.52) in the pre-intervention period (P = 0.02).

The hospitalwide and intensive care Statistical Process Control charts demonstrated eight or more consecutive data points on the same side of the mean indicating a shift in the process and a reduction in MRSA in the intervention period.

Segmented Regression Analysis demonstrated the maximum and conservative estimates for percentage reduction in new MRSA patients hospitalwide (including intensive care) were 79.5% and 42.0% and for MRSA bloodstream infections alone hospitalwide (including intensive care) the maximum and conservative estimates were 87.4% and 39.0% respectively.
Infection control resources required to establish and maintain the intervention program were an Infection Control Practitioner employed for 20 hours per week at a cost of $38,900 per annum. The limited interventions showed a significant reduction hospitalwide in the number of new patients acquiring MRSA and the number of patients who developed a MRSA bloodstream infection. This reduction was achieved without having to isolate patients or conduct MRSA screening cultures.

Application of EQuIP Principles

Customer focus
- Our hospital infection control committee has a consumer representative and all aspects of the project including planning implementation and reporting occurred via this committee.
- Progress reports were included in the hospital newsletter to keep our consumers informed.
- Summary reports were including in The Alfred Annual Review and the Bayside Health Quality of Care Reports.
- During the project the infection control team regularly presented in peer review forums.

Effective leadership
- The infection control team managed the project. This team is multidisciplinary and has a high profile across Bayside Health.
- The project engaged nurse managers who took on a leadership role for the project at a local level.
- Heads of units were targeted for routine regular feedback including patient details in relation to infection or colonisation with MRSA.

Continuous improvement
- Using statistical process control charts rather than tables to feedback MRSA data was a way of letting a picture do the talking and encouraged staff to think about what might be happening at a local level that may offer an opportunity for improvement.
- Using lay terms on the Statistical Process Control charts to identify 2 and 3 sigma control limits assisted staff without a background of Statistical Process Control in interpreting the charts.
- Meeting with an Infection Control Practitioner monthly encouraged staff to talk about not only MRSA but also other infection control issues.
- The monthly meeting offered an opportunity to discuss the basic rules of interpreting control charts for special causes and trends in the data in lay terms rather than statistical terms.
- Discussing individual patients at these sessions put a human face on the problem.
- As the picture changed and MRSA started to reduce staff took pride in their role in the project.

Outcomes
- The reduction in MRSA was seen in a setting in which active surveillance cultures and multimodal strategies and isolation of patients was not used.
- The project was found to be less costly than other reported strategies such as active surveillance cultures and multimodal projects.
- Statistical Process Control charts were found to be simple and easily understood and helped engage staff in the quality improvement project.

Striving for best practice
- Building on work first undertaken by Curren et al (2002) we have shown that interventions that utilise statistical process control MRSA feedback programs demonstrate a reduction in MRSA in another healthcare setting.
- The project was well supported within the organisation including executive management, ward management and Heads of Units.
In order to share the information with our peers the work has recently been published in the Infection Control and Hospital Epidemiology Journal (Harrington et al 2007).

**Innovation**

- In the speciality of infection control in Victoria the use of statistical process control charts is limited and this project demonstrates how measurement and Statistical Process Control can be applied in this area.
- This project demonstrates a more effective means of reducing rates of MRSA without having to isolate patients which may have a negative effect on the emotional well being of the patient (Duff 2002).
- The project is in alignment with recognised state government initiatives aimed at fostering innovation through private-public partnerships, which are underpinned by science and research as it was funded in part by industry (Innovation Leadership Forum 2006).

**Applicability to Other Settings**

The interventions are applicable to other hospitals and healthcare settings, other types of antibiotic resistant organisms or other quality improvement strategies that are aimed at reducing hospital associated infections.
Review the Effectiveness of Asthma Education and Support Programs for Children to Reduce Readmissions to Hospital
Murwillumbah District Hospital, Murwillumbah Community Health Centre, Murwillumbah, NSW

Author
Karen Marsh  Community Paediatric Nurse, Murwillumbah Community Health Centre

Aim
This project aims to review the effectiveness of asthma education and support programs for children 18 months – 15 years of age who are admitted to Murwillumbah Children’s Unit with mild to moderate asthma.

Abstract
Asthma education for caregivers whilst children are inpatients and then follow-up education once home reduces readmission rates to hospital within 28 days.

Asthma is a common childhood condition, the severity and frequency may be decreased by careful planning in consultation with caregivers, patient/client and health care providers.

Medical records of children aged 18 months to 15 years with a primary diagnosis of mild to moderate asthma were audited for the 2001 calendar year which was used as the control group to determine the readmission rate as this was prior to the implementation of current education methods. Further audits were conducted in the 2006 calendar year which had consistent education and follow-up for the majority of admissions. Readmission was measured as being within 28 days.

Comparative results indicate improvement in inpatient education from 63% in 2001 to 89% in 2006 and education / support on discharge home improved from 54% in 2001 to 89% in 2006. Children with a primary diagnosis of asthma readmitted to hospital with asthma within 28 days (ACHS Paediatric Clinical Indicator 2.3) were reduced from 10% in 2001 to 0% in 2006.

Application of EQuIP Principles

Customer focus
- As this project was conducted by the Community Paediatric Nurse the focus for this section is upon that service.
- Telephone contact was attempted by reception staff to all families who were referred to the Community Paediatric Nurse. Of six families who were able to be contacted, four families participated.
- Families were asked two questions:
  - Were you satisfied with the discharge service that you received? All 4 participants were very satisfied that’s 100%.
  - Would you use this service again? Three families indicated yes and one family would only use the service for one of their children not the one who we had already seen.

Effective leadership
- NUM Community Health Murwillumbah allowing quality project to be conducted during work hours.
- NUM Murwillumbah District Hospital  Children’s Unit and staff provide education on the ward to families
General Practitioner’s of Murwillumbah follow-up children post discharge and provide education and support
Paediatrician’s follow-up children post discharge and provide education and support
Community Paediatric Nurse follow-up children post discharge to provide education and support

Continuous improvement
Outpatient follow-up is used as a back up and to reinforce inpatient education.
Key clinical indicators monitored monthly by children’s unit staff and Quality Co-ordinator. This monitoring highlights asthma readmissions within 28 days

Outcomes
Decrease in hospital readmission rates to 0%.
Decrease in avoidable admissions.
Reduction in Hospital bed days cost $700 / day for 3.91 days. Saving per year $1139 x 4 x 3.91 = $17,568
Reduction in the cost of ambulance transfer to hospital for readmission. 2 ambulance transfers over a 12 month period.
Increase in quality of life for the child and family.

Striving for best practice
A randomised unblended controlled study in Leicester, UK also showed a drop in readmission rates of children with asthma if they had a structured discharge package of education. This study looked at similar ages 2-16 years but had their control group running at the same time as the study group. One group were given the discharge education package and the control group was not. The time frame for readmission was 6 months from discharge. Re-admission rates went from 39% in the control group down to 8% in the study group.
(Wesseldine, McCarthy, Silverman, 1999:113)
A randomised control study of structured asthma education and home management was conducted in Glasgow, UK showing a reduction in asthma readmission rates. This study again looked at the 2 years and older Paediatric group presenting with asthma. A control group was looked at over the same time as the intervention group as with the above study. Readmission rates in the control group were 24.8% whereas the intervention group dropped down to 8.3%.
(Madge, McColl, Paton 1997:223)
Benchmarking with The Asthma Clinical Nurse Consultant at The Children’s Hospital Westmead.

Innovation
This project covers the entire continuum of care for the patient/client. It shows that care can be effectively continued from the hospital out in to the community.
A thorough literature search did not reveal any projects addressing care across the continuum, only care in either the hospital or once discharged

Applicability to Other Settings
The long term aim is to extend this project throughout the Tweed/Byron network and repeat the results found in Murwillumbah in other sites within the network.

References
Available URL:http://ebn.bmj journals.com <Accessed 2006, October, 17>


Right Drug, Right Dose, Right Administration: The Patients’ Perspective
Allamanda Private Hospital, Quality Department, Southport, QLD

Author
Gail T. Dacey

Aim
The project aimed to describe the knowledge and understanding patient’s have of their current medications when being admitted to hospital and identify the type of information patients would like to have about their medications before being discharged from hospital.

Abstract
This project is a scientific research project underpinned by a desire to provide consumer input into health care delivery. The outcomes will present a sound basis to achieve improvement and quality care to meet consumer needs.

The design of the project was a simple survey design using three brief questionnaires that had been used in previous studies. Patients being admitted through the Accident and Emergency department of a private health care facility were invited to be part of the project, those consenting to take part formed the convenience sample.

Participants were required to complete two of the questionnaires in the Accident and Emergency department and then completed the third questionnaire the day before they were discharged. The questionnaires were accessed by the researcher only and kept in a secure environment.

Information on the questionnaires was entered into a statistical computer program for analysis.

The statistical results gave a picture of the sample of patients; identified their medication knowledge and compliance on admission; and identified their perception of learning needs to manage the knowledge required to understand and administer their medications at home.

Application of EQuIP Principles

Consumer focus
- Information obtained from the project was from the consumers’ perspective.
- Aim of the project to gather data about the consumer’s needs and expectations.
- Consumer participants believed their views were valued by the organisation.
- Changes to service based on the needs of the consumer.

Strong leadership
- Implementation of the project highlighted to all staff the opportunity to reduce medication misunderstanding for the patient and improve the quality of service in this area.
- Continual feedback and updates via newsletters and PowerPoint presentations encouraged and motivated the staff to contribute to the project.

Continuous improvement
- The result of the project provides scientific data through the stringent collection and analysis.
- Improvements in the quality of medication information giving are of benefit to the consumer, the organisation and the community.

Striving for best practice
- Best practice in Health Care can be achieved through the use of evidence-based care.
• Utilising the scientific method of research for the project the results have a strong evidence base together with their consumer focus.

Applicability to Other Settings
• Results will be submitted for publication in scientific refereed journals nationally and internationally.
• Although the use of a convenience sample reduces the generalisability of the results from a purely scientific perspective, other settings can still make use of the information at their discretion.
• Further information related to the changes in information giving can also be of benefit to other settings.
Rural Model of Service Delivery for People with Spinal Cord Injury (SCI) in NSW: Promoting Access to Health Care and Building Capacity of Clinicians to Deliver Services Locally
Royal Rehabilitation Centre Sydney, Spinal Outreach Service, Ryde, NSW

Acknowledgments:
Motor Accident Authority NSW
Steering Committee of the Rural Spinal Cord Injury Project
Rural Networkers Rural Spinal Cord Injury Project
Spinal Outreach Service
Prince of Wales Hospital
Royal North Shore Hospital
Royal Rehabilitation Centre Sydney
ParaQuad
Spinal Cord Injuries Australia

Author(s)
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Aim
The model aimed to improve equity of access, minimise risk of adverse health events and hospitalisations, build local clinician’s capacity to identify and manage health risks, and make appropriate linkages.

Abstract
The Motor Accident Authority (MAA) funded the Rural Spinal Cord Injury Project (RSCIP) to examine the specific needs of rural people with SCI. This provided opportunities to identify issues relating to the provision of rural services in NSW and enabled a sustainable model of service to be recommended: the Rural Spinal Cord Injury Service (RSCIS). The goal is to ensure more equitable delivery of specialist spinal services in rural NSW, in partnership with local agencies and service providers. The service has been integrated into the Spinal Outreach Service and has achieved the outcomes listed below:
• An accessible statewide multi-disciplinary assessment opportunity within a clinic environment.
• Education and support to rural clinicians.
• Alignment of metropolitan and rural services.

Application of EQuIP Principles

Customer focus
• The model ensures more equitable delivery of specialist spinal services to consumers in rural NSW, in partnership with local agencies and service providers.
• Establishment of the opportunity for consumers to access specialist clinical spinal support.

Effective leadership
The model demonstrates responsibility and commitment to providing an accessible statewide multi-disciplinary assessment opportunity within a clinic environment and alignment of metropolitan and rural services.

1 Rural Spinal Cord Injury project report 2006, Phase 2
Continuous improvement
Ongoing education and support to rural clinicians is an integral part of the model to ensure continuous improvement by the clinicians as well as by the project team. The arrangement provides opportunity for feedback to further develop the model.

Outcomes
- An accessible statewide multi-disciplinary assessment opportunity within a clinic environment.
- Education and support to rural clinicians.
- Alignment of metropolitan and rural services.

Striving for best practice
- Opportunity for health promotion/health maintenance reviews and monitoring within a recommended time frame.
- Opportunity for prevention of avoidable hospital admissions.
- Identification of complex presenting health issues and referral to specialist services.
- Supporting the professional development of rural clinicians through a statewide education program.

Innovation
- Needs of rural clients and clinicians have been identified through needs assessment and piloting of a statewide project.
- Rural Clients have access to a spinal specialist multidisciplinary review closer to their home on an annual basis.
- Rural Clinicians have access to spinal specialist education closer to their place of employment.

Applicability to Other Settings
- Conditions where rural people need to access other specialised areas requiring specialist medical and multidisciplinary support such as other chronic neurological conditions for example, multiple sclerosis, cerebral palsy and motor neurone disease.
- Providing specialist services closer to the client's home has physical, psychological, financial and social benefits.
Rural Multipurpose Service Provides Palliative Care After-Hours Telephone Support Service
North Coast Area Health Service, Dorrigo Multipurpose Service, Dorrigo, NSW

Author(s)
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Vince Carroll  EO/DON, Bellingen and Dorrigo Health Campuses
Jane Phillips  Project Officer, Mid North Coast Rural Palliative Care Program
Mid North Coast Division of General Practice

Aim
To reduce unnecessary presentations/admissions to hospital after hours by increasing access to effective and appropriate palliative care services for clients and their families in the Coffs Harbour / Bellingen area within 18 months

Abstract
After-hours telephone support is a useful resource for people with a life limiting illness and their caregivers, as it provides increased access to information, assistance with decision making, communication and support outside normal working hours. The After-hours telephone support service, based at Dorrigo Multipurpose Service, was implemented as part of the Mid North Coast Rural Palliative Care Program 2004-2006 and the service was evaluated favourably by consumers with results indicating decreased usage of acute care services.

The model of integrating an After-hours telephone support service with existing service delivery models that philosophically align with a quality palliative care approach is cost effective in supporting the needs of health users at what if often a vulnerable time and reduces the burden of unnecessary presentations/admissions to acute care. The after-hours telephone support service is seen as an integral part of quality service planning for palliative care within the Coffs Harbour region.

Application of EQuIP Principles

Customer focus
• support 24 hours a day to manage the complex process of caring for the dying at home
• access to a dedicated service by trained professionals in a time of need
• service provision in a setting absent of competing priorities
• service that is appropriate to their needs and wishes.

Effective leadership
• active engagement in consultative process
• staff information session by expert on the benefits to consumers, anticipated utilisation rate, availability of additional expertise and answers to individual concerns raised,
• one on one education sessions on the computerised database until confidence was established
• development of clinical decision-making protocols prior to implementation
• availability of supporting documentation and resource kits
• mentoring by the Mid North Coast Rural Palliative Care project officer
• defined feedback mechanisms, and
• debriefing support by specialised palliative care team if required
• integrated care model with effective engagement of health, community and consumer partners
• cost neutral service enhancement building a sustainable capacity of care
• advanced information technology / use of electronic health record.

Continuous improvement:
Plan:
• workshop to identify strengths & weaknesses in network palliative care delivery and strategies for improvement
• consultation and education
• information technology infrastructure and staff training in use
• memorandum of understanding between project partners
• clinical decision-making protocols, triage record sheets, policy and resource kits to guide practice
• clinical governance and quality assurance.

Do:
• implement program.

Check:
• quality assurance review of 25% of all records 3 monthly
• actively monitor, assess, evaluate processes and results
• feedback & debrief sessions
• realign to project aims and objectives as required.

Act:
• standard practice.

Outcomes
• 21% registered participants used after-hours telephone support service
• 55 occasions of service in 18 month period
• service accessed by carer in 80% cases
• 78% calls occurred between 1800hrs and 2400hrs
• 94% patients remained at home with symptom management and reassurance
• medication usage: pain, symptom management and anxiety main reason for accessing after-hours service
• continuity of care for palliative care client in preferred setting
• cost neutral model.

Striving for best practice
• advice based on evidence based protocols
• shared database for transfer of real time information between specialist team and staff at Dorrigo

Innovation
• PalCIS electronic database
• new concept in models of care for Rural Multipurpose Service
• cost neutral service enhancement integrated into daily practice.

Applicability to Other Settings
• expand to support Residential Aged Care Facilities so residents can age in place without the need for transfer to an acute facility
• viable cost neutral option for other networks of the NCAHS
• transferability to AHS that lack infrastructure and resources to develop and sustain a stand alone 24 hour telephone information and advice service.
Social Emergency Team (S.E.T) - Decreasing Violence: Increasing Communication
Northern Health - Stream 2 (The Northern Hospital), Social Work and the Executive Team, Epping, VIC

Author(s)
Ingrid Ioannidis Social Work Site Manager on behalf of the SET committee:
Doreen Power Operations Director Emergency dept and Women's and Children's Health Unit
Jessica Beattie Patient Advocate
Peter Champ Social Work Health Services Manager
Maree Glynn Operations Director of Medicine
Christine Lamotte Operations Director of Surgery

Aim
Early intervention and interdisciplinary development of a management plan for social situations involving DHS - Child Protection Unit and Victorian Civil and Administrative Tribunal (VCAT).

Abstract
Seven Code relating to violence was called over a period of 7 weeks. The codes placed Social workers, hospital Executive, staff, patients and visitors at risk of both verbal and physical violence. Early communication and planning for management of these events was necessary.

A committee was formed, reviewed the codes and identified the majority of cases involved either Child Protection or VCAT. A SET form was created and completed by Social Workers for all cases involving Child Protection or VCAT. The form includes identifying information, a brief statement about the situation, any threats made and risks to the individual or the organisation. The form includes a communication matrix that records internal and external professionals involved and highlights who needs to be involved.

Initially the process was piloted over an 11 week period to test the strategies put in place. This involved 20 SET forms being completed and resulted in no Code Greys or Blacks being called for Social Emergencies. The initiative has now continued for a period of 12 months. The SET form has been reviewed by the SET committee on three occasions and changes have resulted in improved communication.

The process was reviewed at quarterly intervals post the commencement of the SET initiative. At 12 months 71 SET forms had been completed, 61 relating to Child Protection, 9 relating to VCAT and 1 from a scenario that was thought to be Child Protection but resulted in no report being made. The SET initiative has increased interdisciplinary practice and expanded to be involved with other related projects.

Application of EQuIP Principles

Customer focus
- SET provides a safe environment for patients and visitors at The Northern Hospital.
- Ensures that a child’s welfare is paramount.
- Provides a calm planned approach to managing complex social situations.
- Increases a patients privacy and emotional needs when managing complex situations.
Effective leadership

- Includes interdisciplinary planning at all levels from direct care staff to the executive team.
- Provides direction to the hospital in preparation for the new Children Youth and Families Act.
- Caters for the increase of patients presenting at the hospital and needing to be reported to Child Protection.
- Increases managerial support at several levels to staff, which in turn results in staff feeling safe within their workplace.
- Provides both formal and informal training opportunities encouraging staff to develop, learn and contribute to planning for managing complex social situations.

Continuous improvement

- The committee meets on a monthly basis to review and improve systems in place.
- SET allows for a system of recording the number of reports made to Child Protection and VCAT.
- The initiative is run with the current resources of the hospital.
- Majority of Social Workers have been involved in completion of the forms.
- Introduced to the Social Work orientation program.

Outcomes

- 71 Set forms completed by 12 different Social Workers in 12 months.
- SET has seen the improved communication between multidisciplinary teams and especially between Social Work and the Executive team.
- On 76% of these occasions Social Work reported an increased level of support.
- 40.8% of all forms were completed in the last 3 months.
- 12 different inpatient units were involved in the SET initiative.
- Responding to children at risk (ResCAR) committee has been formed incorporating all key players within the hospital.
- Regular Child Protection liaison meetings have been established.
- 3 education sessions held for staff to gain a better understanding of the role of VCAT (Victorian Civil and Administrative Tribunal).
- Initiative presented at Child Protection, Clinical Risk Management and Quality week educational forums and a research poster presented during research week.
- Research commenced into identifying and managing domestic violence in the Emergency department.
- SET has seen the improved communication between multidisciplinary teams and especially between Social Work and the Executive team.
- SET has provided a better understanding of each others roles and ultimately a better response to patients, families and the broader hospital community.

Striving for best practice

- SET recognises and respects each disciplines expertise and works together to produce the best outcomes for patients, visitors and staff.
- Provides staff with a better understanding of the laws relating to Child Protection and Guardianship and Administration.

Innovation

- Has not been instigated at other hospitals.
- DHS recently held forums statewide about best practice frameworks for acute health services and showed interest in the SET initiative.

Applicability to Other Settings

High potential and interest from other hospitals to be integrated into their systems.
Standardisation of Cardiopulmonary Resuscitation (CPR) Equipment and Processes Across a Tertiary Healthcare Facility
Royal Brisbane and Women’s Hospital, District Safety and Quality Unit, Herston, QLD

Author(s)
Stephen Brand CNC – District Clinical Emergency Response Coordinator, District Safety and Quality Unit
Lloyd Warner Manager, Clinical Equipment Loan Service, District Safety and Quality Unit

Aim
To standardise equipment and processes for resuscitation trolley’s located in the general clinical areas of the Royal Brisbane and Women’s Hospital.

Abstract
A project methodology was utilised for this quality initiative within a multidisciplinary team structure. Outcomes of this project included the following:
• Improved patient safety through standardisation of CPR consumables and equipment.
• Increased staff familiarisation was achieved through standardisation of consumables, equipment, trolley setup and checking guidelines for the trolley.
• Significant reduction in time for staff to perform routine safety checks of the resuscitation trolley.
• Improved staff training processes through standardisation of the resuscitation trolley.
• Improved compliance with consumable product expiry date.
• Reduction in excess consumable equipment being stored on the trolley.
• Development of a monitoring process for equipment usage.
• Development of a reporting mechanism for identified variances of equipment usage.

Application of EQuIP Principles

Customer focus
• Primary focus for this project was the patient / person requiring immediate life saving interventions within the clinical areas of the organisation. Standardisation of equipment allows for increased familiarity of all staff with emergency equipment regardless of where the resuscitation attempt occurs. Infection control best practice principles are able to be applied through utilisation of disposable equipment being stocked on the resuscitation trolley.
• Clinical staff were consulted throughout the project and several benefits for this group were achieved. A significant reduction in the time required by staff to perform a safety check of the trolley was achieved through standardisation. A centralised area within the organisation for production and supply of emergency equipment packs.

Effective leadership
Strong leadership was demonstrated organisationally through the Emergency Response Committee which approved and oversaw the whole change process as a demonstration of it’s role within the clinical governance framework of the district.

Continuous improvement
An outcome of the project enabled continuous monitoring of emergency equipment usage and identified issues related to emergency equipment to be further investigated.
**Outcomes**

- Improved patient safety through standardisation of CPR consumables and equipment, including light sources required for intubation contained on the Standard Resuscitation Trolley.
- Increased staff familiarisation was achieved through standardisation of consumables and equipment, trolley set up and standard checking guidelines for the trolley.
- Significant reduction in time for staff to perform routine safety checks of equipment and consumables contained on the trolley.
- Improved training processes for emergency equipment through standardisation of equipment, checking guidelines and development of an intubation equipment training pack.
- Improved compliance with consumable product expiry date.
- Reduction in excess consumable emergency equipment being stored on the Standard Resuscitation Trolley.
- Development of a monitoring process for pack usage and equipment issues as identified by clinical staff through collaboration between CELS and CNC - Clinical Emergency Response Coordinator.

**Striving for best practice**

- The simplification of processes, standardisation of equipment and continuous monitoring are the basis of striving for best practice and is very well demonstrated in this project.
- Literature and internet searches were not able to identify any hospital with which this project could be benchmarked with, so at this stage benchmarking is not possible.

**Innovation**

- Development of single use intubation and intravenous equipment packs for implementation onto the resuscitation trolley in clinical areas.
- Standardisation of equipment and processes regarding emergency equipment within a tertiary healthcare facility.

**Applicability to Other Settings**

This project can be applied to healthcare facilities where a centralised equipment loan / distribution service operates.
Team Centred Behaviour Based Approach to Correct Site Surgery
South Perth Hospital, Nursing, Como, WA

Author
Alison Hales  Project Officer

Aim

Abstract
The methodology involved:
Methodology consisted of 8 defined Phases two additional phases were added to include Critical Customer Satisfaction Survey and a Behaviour Based Learning Tool.
Phase 1: Completion of the initial Consultation with major stakeholders.
Phase 4: In-Service Education prior to trial of the MR 66A and Correct Site Safety System 5 Step Protocol
Phase 5: Completion of the initial Audit of the Process. And report.
Phase 6: Assessment, Evaluation and feedback of initial trial and the commencement and completion of Trial.2.
Phase 7: Completion of a final Audit of the ‘Time Out’ document.
Phase 9: Development of a Behaviour Based Safety Resource Tool.
Phase 10: Completion and correlation of all Audit Results to allow Data Comparison across the Core Business

Outcomes
31.7.2006 Evaluation and feedback on External Education Tool obtained from 73% of Nursing Staff. 88% found the Resource Tool relevant and invaluable, 6% found it valuable and 6% did not respond.

Audit results 25.10.2006 MR66A document. 5 changes only made to initial document and Trial 2 began. 100% compliance with the “Time Out” Component of the System. 85% compliance with completion of all parts of the documentation, however 41% of document and revealed inappropriate use of abbreviations. 28.2.2007 Second Audit of documentation revealed 100% for document completion. A mean of 96.5% compliance with all system components. The Operation Record “MR66A(2) has now been implemented into the medical record document. Providing Major Stakeholders and consumers with a risk control document. SPH was able to realise its target of 90% compliance across System KPIs. Critical Customer Satisfaction survey scored a mean 8.5/10.

Application of EQuIP Principles
Customer focus
Strategies surrounded the key objectives of:
• Information sharing across the internal customer group of Surgeons, Anaesthetists and Nursing Staff.
• The rights of the customer to participate in the site verification process. The organizations commitment to minimising the risk to all customers of the business.
• Provision of the “Understanding Your Procedure” pamphlet published by the ACQSH 2004 to all Customers of SPH as part of the admission package that customers receive prior to admission to SPH.
• Provision in the development of Local Policy and Procedure Guidelines that supported the Legislation.
• Verbal verification the customer actively participates In the verification of their Surgery/Procedure.
• All Surgical Team members were provided with copies of all Audit Results for their review, participation in one on one In-service education and open forums enabled further information to be shared among the provider group.

Effective leadership
• CNM participated in open forum discussion at professional body level to ascertain issues to the Correct Site System implementation.
• A task force was formed. reported through the CNM to the Executive DON who relayed information to organisational committees.
• Senior Management Level support was evidenced by the visual, technical and professional expertise exhibited at all phases of the project by the CNM .
• Executive support was exhibited in the human and financial resources required to complete the project.

Continuous improvement
Revolved around the following processes:
• Patient Record Audit of the completion of the MR66A Document.
• Observation Audit of the 5 Step Protocols.
• Development and implementation of Variance Data Collection.
• Critical Customer Satisfaction Survey involving Major Stakeholders.
• Development and implementation of a Clinical Near Miss anecdotal reporting System.
• Witnessing verbal communication with Patient and observed marking of the site.

Outcomes
As stated in abstract.

Striving for best practice
• Aligns SPH with government agencies and the Royal College of Surgeons in its prevention of adverse sentinel events.
• SPH abreast of change by adaptation of Systems that are delivered through the Private Sector, Legislation and Industry Quality and Safety Initiatives.
• SPH is now benchmarking practice that improves the clinical safety and reduce the risk of an adverse sentinel event to all of its customers. Evidenced by invitation to present at the following forums PHAQ Innovations in Nursing Conference 2007. Poster Presentation Australasian Safety and Quality in Healthcare Conference 2007. MPSCIIP Successful submission 2006.

Innovation / Applicability to Other Settings
• Copies of the Educational Resource have been shared with Notre Dame University and ideas and processes shared and discussed at professional bodies. Included in their Clinical Governance Unit in the undergraduate program.
• Major Stake Holders of the Core Business are participating in information sharing across the Private Hospital Sector in WA by actively encouraging other organisations to adopt the SPH Correct Site System.
• Behaviour Based Safety Approach can now be used as a model system to be implemented across all systems of health care.
Sustainability

- Forms an integral part of the Patient Safety System Management at SPH
  1) Staff Orientation, 2) Incorporated into departmental KPI.
  3) Learning Tools available for all new customers of the business.
- Appointment of designated project officer to audit system components and report to organisational committees to capture clinical near miss Data.
The Development of a Manual, Methodology and Procedure for Reducing the Risk of Health Care Associated Infection Related to Construction, Renovation, Repairs and Maintenance Within Health Care Facilities
Bendigo Health Care Group, Infection Prevention Control Unit (IPCU), Bendigo, VIC

Author
Jane Hellsten  Manager, Infection Prevention Control Unit

Aim
To minimise risk of infection by having a formal approach to risk management of all construction, renovation and maintenance activities within Bendigo Health.

Abstract
The Infection Prevention and Control Unit, with the assistance of a consultant engineer, developed a methodology, manual and procedure to assist Bendigo Health to manage the risk associated with construction, renovations and maintenance works. Following development of the manual Bendigo Health implemented a comprehensive risk management approach to building works in respect to infection prevention and control. Over the past five years the Infection Prevention and Control unit along with the engineering department have endeavoured to work closely together to manage this risk. Education of engineering staff, contractors, managers and infection control liaison staff has ensured that staff appreciates the potential for infection and the need for risk management of all building works. Formalised processes have been adopted by the Infection Prevention and Control Unit and the engineering department which require early risk assessment, planning and surveillance of building works. Ongoing evaluation of these processes and recognition of the soundness of the methodology by relevant external bodies provides evidence of the suitability of this approach.

Application of EQuIP Principles

Customer focus
- Reducing risk of infection to our patients/clients.
- Assessing population at risk depending on location of building/maintenance activity.
- Staff as our customer – ensuring that staff are aware of risks associated with building and maintenance works and are informed of necessary risk management.
- External Health Care Workers/Engineers/Contractors as our customer – informing the wider health care community through promotion of the manual and the methodology at relevant forums, websites and professional gatherings/groups.

Effective leadership
- Lack of availability of suitable tools within Victoria resulted in the development of a manual.
- The manual and the methodology have been promoted to Infection Control colleagues, for example at the Victorian Infection Control Professionals Association state conference in Melbourne, 2003 and 2005.
- The manual and methodology was presented at a seminar conducted by the Victorian chapter of the institute of Hospital Engineers in Melbourne 2006.
- The Infection Prevention Control unit has been consulted by many health care facilities on how best to manage risks associated with building works.
Continuous improvement

- The manual, procedure and education have been revised. The manual was last revised in 2005, the procedure in 2006, education is revised on an ongoing basis.
- The methods are constantly being refined as more experience is gained with conducting risk assessment and devising how best to manage the risks associated with different building works, sites and patient populations.
- As new knowledge and resources/tools become available the methodology evolves accordingly.

Outcomes

- A sound method for assessing and managing the risk associated with building works, construction and maintenance in a health care facility.
- An informed Infection Prevention Control and engineering department.
- No outbreaks of infection related to building, construction or maintenance works within Bendigo Health since the implementation of this methodology.

Striving for best practice

- Setting the benchmark in risk management of infection related to building works in health care settings.
- Implementing and embedding the methodology at Bendigo Health.
- Evaluating the process on a regular basis to ensure it remains relevant and achieves what it sets out to do.

Innovation

- Developing the manual and promoting it widely.
- Informing the Department of Human Services Victoria.
- Informing the private sector such as contractors, hospital architects.

Applicability to Other Settings

- The methodology is generic and can be applied in any health care related setting.
- Risk assessment and management is based on the setting, the patient/client population and the nature of the works to be carried out.
The Development of a Multidisciplinary Approach to Altering Medication Dose Forms / Routes in the Acute Setting
North West Regional Hospital (NWRH), Pharmacy and Speech Pathology, Burnie, TAS

Author(s)
Dr Pascale Dettwiller  Managing Senior Clinical Pharmacist
Amy Luck   Senior Speech Pathologist

Aim
Within the EQuIP principles, develop and implement a best practice and multidisciplinary approach of acute care for patients with dysphagia, enteral feeding, or who are nil by mouth with regard to altering medication dose forms / routes.

Abstract
The practice of altering medication dose forms (modifying the texture of medications from the proprietor's original manufactured form such as crushing, scoring, emptying the contents of capsules, dissolving compacted powder) is widespread across healthcare settings both in Australia and overseas. There are many safety risks inherent in altering medications, for example altered absorption, adverse pharmacokinetic effects, occupational health and safety issues, local irritant effect, failure to reach the site of action. Despite the risks, altering medication dose forms is a common occurrence for patients who find it difficult to swallow medications whole or who require medication delivery via enteral feeding tubes. There are currently no comprehensive Australian policies or procedures documents available to ensure that the recommendation and administration of altered medication dose forms involves all of the relevant members of the multidisciplinary team and occurs in a manner consistent with best practice standards. This quality project involved an investigation of available policies and guidelines, a literature review to establish current best practice with regard to oral and enteral routes of administration, and the development of a comprehensive policy and procedures document with supporting documentation, including decision-making pathways for pharmacy staff, clinical guidelines for nursing staff and up-to-date Australian medication information. This outcome reduces the potential risk to patients and addresses the process of altering medication dose forms from the time that it is identified that the patient is unable to tolerate whole medications, through the recommendation, administration and discharge planning stages. It ensures that patients have access to timely and appropriate multidisciplinary care and demonstrates consumer focus by reducing the risks associated with the activity and ensuring that informed consent occurs and that appropriate education is received by the patient and carer prior to discharge. A system for ensuring the effectiveness of the project has been implemented. Finally, in an increasing aging population, inappropriate medication management of patients with dysphagia as a consequence of various clinical conditions can lead to real risks for the safety of the consumers as well as for healthcare staff. This project was designed to minimise these risks in an acute care setting and to ensure an appropriate system for transfer of information was in place to maintain a continuum of care through the development and implementation of adequate policy and procedures.

Application of EQuIP Principles

Customer focus
• To improve safety and quality use of medicines in a growing population at risk.
• To reduce the risks related to administration of altered medication dose forms/route.
• To ensure appropriate information is delivered by prescriber on risks and consent to changes to patients and to carers through appropriate counselling during the process.
• To improve the continuum of care when customer’s of level of care is changing.

**Effective leadership**
• To create leadership through recommendations and guidance for the multidisciplinary team.
• To outline roles of the team member.
• To enhance evidence-based medicine practices through education and training.

**Continuous improvement**
• To create a system for implementing and up-dating through follow-ups and evaluation involving all stakeholders.
• To assure the EQuIP principles are followed and maintain.

**Outcomes**
• To assess the risk prior to implementation and set benchmarks for the management of these risks.
• To create policy procedures and supporting documents.
• To implement through education and training.
• To monitor the implementation and maintain follow-ups.

**Striving for best practice**
• To improve the hospital standards by creating and developing a comprehensive policy and procedures incorporating the best current practice and to create a multidisciplinary approach of the dysphagic patient.
• To satisfy to the Australian Pharmaceutical Advisory Council guidelines (2002).
• To improve patient care and outcome through improved practices.

**Innovation**
• A holistic and multidisciplinary approach to altering medication dose forms/routes and improving patient care.
• Consideration for the continuum of care at all levels as a priority in reducing medication risks.
• Provides a new approach to the need for improvement in a growing area of practice and addresses public concern for lack of standard of practices.
• Addresses the technical aspect of the practice and also the need for standards and reference for the different stakeholders.

**Application to Other Settings**
The outcomes are translatable to any acute care or aged care facility.
The Development of Innovative Service: onTrac@PeterMac Adolescent & Young Adult Cancer Program
Peter MacCallum Cancer Centre, Social Work Department, Division of Haematology & Medical Oncology, Melbourne, VIC

Author(s)
Kate Thompson Team Leader
Dr David Thomas Medical Director, onTrac@PeterMac Adolescent & Young Adult Cancer Program

Aim
To develop Australia’s first multidisciplinary service aimed at improving quality of life and survival rates for adolescents and young adults (AYA) living with cancer.

Abstract
There has been a marked increase in the incidence of cancer in adolescents and young adults (AYA) within Australia during the past decades. However, cancer during adolescence and early adult life is currently underestimated, under-researched and under-resourced. Adolescents & Young Adults (AYA) with cancer pose a unique challenge to current health systems and the professionals working within them. Throughout the world it is increasingly recognised that the needs of this particular group of patients may not be met through existing services within the paediatric or adult systems. The underlying problems appear to relate to a complex set of interactions between the healthcare system and the prevalence of cancer in this age group and the unique psychosocial and developmental needs of this population group.

onTrac@PeterMac Adolescent & Young Adult Program is Australia’s first multidisciplinary clinical and research team of healthcare professionals working towards improving the survival rates, quality of treatment and care of this population group through the establishment of:

- a dedicated state-wide AYA cancer team
- a research and development program
- a health promotion, training and education program; and through
- effective leadership in advocacy and policy development in AYA cancer care.

Application of EQuIP Principles

- onTrac@PeterMac Adolescent & Young Adult Cancer Program is consumer focused and was developed in response to the identified unmet need expressed by AYA cancer patients through focus groups, population based questionnaires and interviews examining the ‘adolescent & young adult cancer experience’.
- onTrac@PeterMac has developed collaborative relationships with consumer advocacy groups CanTeen and Redkite.
- onTrac@PeterMac has demonstrated effective leadership through the development and provision of a state-wide service to all young people undergoing cancer care regardless of treatment or geographical location.
- onTrac@PeterMac’s Education & Training Program has increased the knowledge and skill base of professionals providing care to AYA and their families throughout Victoria.
- onTrac@PeterMac has incorporated a wide variety of processes which includes methods to evaluate many aspects of the programme ensuring continuous improvement in services is provided.
- Over 400 patients have been referred to the program since March 2004 and on average 25 secondary consultations are provided each week to Victorian healthcare providers.
Current development of a best practice framework for healthcare professionals working with AYA cancer patients incorporating best practice recommendations for healthcare systems and learning tools for clinicians.

National & International Research Presentations: The Connective Tissue Oncology Society (Venice 2006); International Psycho-Oncology Society (Venice 2006); CanTeen National Conference (Sydney 2006); Change Champions (Melbourne 2006), International Social Work in Health & Mental Health (Hong Kong 2006).

In 2007 onTrac@PeterMac has transited to funding from the Victorian Governments Department of Human Services, based on demonstrated outcomes and the importance of world class health care to Victorian cancer patients.

Innovation

Australia’s first and, currently only multidisciplinary Adolescent & Young Adult Cancer Service based in the adult health setting delivering a state-wide service.

Establishment of an Australian first AYA health promotion, training and education program.

World first AYA psychosocial research programme which has produced the following outcomes (i) Focus Groups identifying unmet need amongst AYA cancer patients, (ii) Longitudinal psychosocial research study, (iii) development of a patient diary (iv) Australia’s first AYA survivorship group.

Establishment of Australia’s first dedicated AYA cancer website for young people, families and healthcare providers.

onTrac@PeterMac has been widely publicised in the press as an innovative model of care providing services to individuals and the community.

Applicability to Other Settings

onTrac@PeterMac provides representation on the national AYA reference group hosted by Cancer Australia, and as part of the Clinical Oncology Society of Australia.

onTrac@PeterMac was invitation to present the model of service delivery at Cancer Australia & Clinical Oncology Society of Australia, National Forum, Sydney 2007 as a national agenda for AYA cancer care is established.

onTrac@PeterMac has developed international collaborations with AYA treatment, research and teaching centres in UK, US and NZ.

“I felt like I was the only person under 60 being treated for cancer. Each day I would go to hospital and sit in the day ward with twenty other people. The youngest person was about 55. My nurse told me about onTrac@PeterMac. I called them and they invited me a movie night. I got to come to Melbourne and meet fifteen other people my age. Even though they are treated at other hospitals, we now talk on MSN and SMS with each other all the time. I’m going to the Christmas party bowling and Ill see them there again” James 18 years old (Focus Group Transcript 2004: Isolation of Young People in the Adult System)
The Medical Emergency Team (MET) or the Medical Education Team: What Really Works?
Southern Health, Quality Unit, Clayton South, VIC

Author(s)
Associate Professor Michael Buist
Ellie Abaloz
Dr Julie Harrison
Susan VanDyk

Aim
To ensure that patients who are clinically unstable as per the hospital MET criteria are actually responded to by the MET team in order to minimise our hospital cardiac arrest incidence.

Abstract
*Problem:* In hospital, cardiac arrest is a poor clinical experience for any patient and often represents failure of optimal clinical care. However, the use of medical emergency teams as a system of care to prevent such events is controversial. Several single centre historical control studies have demonstrated significant reduction of in-hospital cardiac arrest incidence, however the only randomised prospective study could show no such benefit. This study reported a significant problem with failure to call the MET or cardiac arrest teams when patients fulfilled MET criteria prior to in-hospital cardiac arrest.

*Design:* A single centre, prospective audit of hospital cardiac arrest and medical emergency team data for the calendar years 2000 to 2005 inclusive.

*Setting:* A 400-bed general outer suburban metropolitan teaching hospital.

*Strategies for change:* Three educational initiatives in our institution to improve MET compliance; intern orientation program, intensive care unit (ICU) nurse liaison program and the medical registrar professional development course (MET-CRM).

*Key measures for improvement:* Cardiac arrest incidence.

*Effects of the change:* An annual reduction of cardiac arrest incidence of 25% per annum from 2.4/1000 admissions in 2000 to 0.66/1000 admissions in 2005.

*Lessons learnt:* A system of care like the MET can be efficacious when supported with a multi-disciplinary multi-faceted education system.

Application of EQuIP Principles

**Customer focus**
- MET has a primary focus on the management of clinically unstable in-hospital patients.
- Intern orientation and MET-CRM are aimed at improved compliance with MET and better patient outcomes.
- ICU nurse liaison provides a directed customer focus for at risk patients.

**Effective leadership**
- MET provides immediate, timely and appropriate leadership in often difficult clinical circumstances.
• Intern orientation, MET-CRM and ICU nurse liaison are all educational programs that teach, encourage, and support hands on clinical bedside leadership.

**Continuous improvement**
• Cardiac arrest incidence reduction has been a continuous improvement at our hospital for more than a decade.
• Intern orientation, MET-CRM and ICU nurse liaison are all strategies directed at this quality indicator.

**Outcomes**
An annual reduction of cardiac arrest incidence of 25% per annum from 2.4/1000 admissions in 2000 to 0.66/1000 admissions in 2005.

**Striving for best practice**
A cardiac arrest incidence of 0.66/1000 admissions is one of the lowest reported for an acute care hospital in the western world.

**Innovation**
• Our hospital educational initiatives and ICU nurse liaison program have created a culture and permanent Hawthorne effect to drive these outcomes.
• In the future we hope to implement electronic graded escalated bedside notifications to determine the most appropriate timely clinical response for our unstable general ward patients.

**Applicability to Other Settings**
• These results have been quoted as support for the Institute of Healthcare Improvement (USA) saving 100k lives program (2005).
• Part of the data to support the Australian Quality Council MET platform “Safer Systems Saving Lives” program (2006).
• Quoted as part of the information in support of the findings for the 1st International Consensus Conference on MET (Pittsburgh, PA 2005).
The Physiotherapist-led Orthopaedic Assessment Clinic (OAC)
Royal Children’s Hospital – Melbourne, Surgery Program, Parkville, VIC

Author(s)
Mr Leo Donnan Associate Professor, Chief of Surgery
Mrs Prue Weigall Senior Orthopaedic Physiotherapist
Mrs Sharon Vladusic Senior Orthopaedic Physiotherapist

Aim
The establishment of a physiotherapist-led orthopaedic screening clinic (OAC) to reduce waiting times for orthopaedic outpatient appointments and provide high quality orthopaedic care for children

Abstract
The physiotherapist-led OAC was developed in 2005 in response to long waiting times for appointments with orthopaedic consultants at Royal Children’s Hospital, Melbourne. The OAC is a screening clinic which provides an entry point for orthopaedic assessment and facilitates the delivery of timely and high quality orthopaedic care for children. An audit was taken of pre-existing waiting lists and the waiting times for the urgent, semi-urgent and non-urgent orthopaedic outpatient referrals. Triage sheets were developed to identify the target group to OAC, based on the diagnosis specified in the referral letter. Training of the physiotherapist was provided by the orthopaedic surgeons in their outpatient clinics, particularly in assessment and management of hip dysplasia and talipes (clubfoot). Fact sheets on paediatric orthopaedic conditions were developed by the physiotherapists for parent and referrer education. The OAC initiative has been successful in significantly reducing waiting times for orthopaedic outpatient clinics, with positive feedback and support from the orthopaedic consultants. A recent outpatient consumer evaluation survey showed a high consumer satisfaction with the care provided through the OAC. A second full-time physiotherapist was appointed in 2006, and funding has been recently obtained for a third physiotherapist to meet demand and further reduce waiting times.

Application of EQuIP Principles

Customer focus
- Improved access to orthopaedic services, resulting in reduced frustration and anxiety levels of parents and children.
- Establishment of orthopaedic fact sheets to educate parents and health care providers.
- Family-centred model of care, focus on informing and empowering parents.

Effective leadership
- The physiotherapy-led OAC is an innovation in workplace design that has successfully improved orthopaedic care for children in Victoria.
- Strengthening of career pathways for senior clinical physiotherapists, to improve job satisfaction, retention and career opportunities.
- Involvement in orthopaedic research projects with consultants.

Continuous improvement
- Recent outpatient consumer evaluation survey to provide feedback on OAC and ways to improve orthopaedic services to children and families.
- OAC initiative builds on the strong partnership already established between physiotherapists and orthopaedic surgeons at RCH.
- Regular of review of referral numbers and waiting lists for orthopaedic outpatient clinics.
• Meetings with administrative support staff to address problems/concerns of clinics.
• Funding recently obtained for a third physiotherapist to meet demand and further reduce OAC waiting times.

Outcomes
• Waiting times for semi-urgent referrals to general consultant clinics reduced from 3 months to 2-3 weeks.
• Waiting times for non-urgent referrals to general consultant clinics reduced from 15 months to 1 month.
• Waiting times for non-urgent referrals to OAC reduced from 15 months to 4 months.
• High consumer satisfaction of care provided, as measured in recent outpatient consumer evaluation survey.
• Positive feedback and support from RCH Orthopaedic Consultants.

Striving for best practice
• The physiotherapy-led OAC is an innovation in workplace design that has successfully improved orthopaedic care for children in Victoria.
• OAC developed following successful implementation of extended scope practice for physiotherapists in UK.
• Funding recently obtained for a third physiotherapist to meet demand and further reduce OAC waiting times.

Innovation
• New role for paediatric physiotherapists in Australia.
• The physiotherapy-led OAC is the first of its kind in a paediatric hospital in Australia.

Applicability to Other Settings
• OAC model could be applied to orthopaedic outpatient clinics in hospitals throughout Victoria and Australia.
• Clinics such as the OAC provide a safe, clinically effective and cost effective assessment and treatment option for patients not needing to see a consultant/specialist.
• Senior physiotherapists in an OAC role can assist in decreasing waiting times for outpatient clinic appointments, reduce unnecessary workload for consultants, and provide increased availability of physiotherapy treatment for patients with musculoskeletal conditions.
The Sister Francesca Healy Cottage
St. Vincent’s - Health Service Demand & Mental Health, FITZROY, VIC

Author(s)
Anne Maddock              Manager – Clinical Governance

Aim
To deliver high quality healthcare to people experiencing homelessness

Abstract
The Sister Francesca Healy Cottage, known as The Cottage, is the only facility of its kind in Australia that provides Hospital in the Home healthcare for the people experiencing homelessness. People experiencing homelessness may be frequent presenters to emergency departments, with the same or worsening condition. Their living situation is often not conducive to recovery and they have few links with service providers.

The Cottage, a six-bed facility housed in a small terrace opposite St. Vincent’s Hospital, provides healthcare in a supportive home-like environment that aims to address some of the long term causes of the patients’ illnesses. For many it is a safe haven. Admission to The Cottage provides nursing, personal care support, reassessment and seeks to improve accommodation and social supports at discharge. It offers an alternative option to hospital admission for a complex group of patients with multiple health and social needs.

From May 2006 – April 2007 The Cottage accepted 243 admissions, with an average length of stay of 5.7 days. The average age was 47. Past medical history of patients shows that 90% have or are experiencing hypertension, suicidal ideation or cannabis/nicotine dependence and 56% have an acquired brain injury. Almost a quarter (24%) live on the streets or in crisis accommodation and 32% live in rooming or boarding house accommodation.

The establishment of The Cottage has resulted in a unique model of care tailored to meet the particular needs of a marginalised patient group and development of a strong network and links between The Cottage, St. Vincent’s and community services.

In 2006, the Cottage developed a detailed service plan that amongst other things identified strengths, weaknesses, opportunities and threats to the service. Quality improvement has been a major focus in 2006 with a number of positive outcomes across clinical, support and corporate areas to improve the quality and safety of services delivered. These initiatives form part of the Cottage’s ongoing quality improvement plan and ensure it continues to deliver a model of care appropriate to its clients’ needs.

Application of EQuIP Principles

Customer focus
- Responds not only to the acute health needs of the client population but also creates an opportunity to address some of the complex psycho-social needs of clients.
- Links the patient with the full range treatment and services offered by St. Vincent’s and also with other community providers.
- Fosters an environment where patients have the best possible chance of improving or stabilising their health and wellbeing.
- Consumer and carer input sought on an ongoing basis and via targeted activities during the 2006 quality improvement program.
Effective leadership
- Mr Byron Trevascus, as Manager of The Cottage provides leadership to the team and within St. Vincent’s in the care of a complex patient group.
- St. Vincent’s identifying an unmet need and was a leader in developing a model such as the Cottage to respond to the complex medical and social needs of people experiencing homelessness.
- Clinicians across disciplines have been leaders in the development and ongoing improvement of services offered by the Cottage

Continuous improvement
- Quality improvement has been a major focus in 2006 with a number of positive outcomes across clinical, support and corporate areas to improve the quality and safety of services delivered.
- These initiatives form part of the Cottage’s ongoing quality improvement plan and ensure it continues to deliver a model of care appropriate to its clients’ needs.

Outcomes
Examples include,
- Improved client feedback, service delivery and communication
- KPIs collected monthly with data communicated to staff and used to influence service delivery
- More informed staff leading to improved client care and advocacy
- Safer, more manageable environment conducive to patient comfort and safety
- Improved linkages with external agencies and advocating opportunities.

Striving for best practice
- The Cottage maintains various external relationships and is represented on committees
- A current research project is being conducted by Melbourne University, seeking to identify key risk factors among homeless people.
- In partnership with ALERT, the Cottage has taken a proactive approach to collection and evaluation of patient data to inform service improvements.

Innovation
- Interdisciplinary, holistic approach to the care of the homeless patient
- Innovative service delivery model, recognised as the only facility of its kind in Australia
- Provides an essential link for patients to re-connect with community

Applicability to Other Settings
Successive reviews of the service indicate that the Cottage could be replicated successfully in other districts and adapted to meet the needs of other patient groups such as younger people, women from backgrounds of domestic violence etc.
The Western QUATRO Project
Barwon Health, Community and Mental Health, Geelong, VIC

Author(s)
Jennifer Black  Project Manager
Tom Callaly  Project Leader
Tania Lewis  Consumer Consultant
Pamela McIntosh  Carer Consultant
Angie Hunter  Project Worker
Louise Moore  Project Worker

Aim
The Western Cluster QUATRO (Quality Through Outcomes) Initiative, led by Barwon Health, was a consumer and carer-focused project that aimed to understand the attitudes of consumers, carers and clinicians towards Routine Outcome Measurement (ROM) and the ways in which it could be used in clinical practice.

Abstract
In 2004 the Victorian Department of Human Services (DHS) set up the QUATRO Network in order to consolidate the routine use of outcome measurement data in public mental health services.

Information was gathered through an initial audit of participating services in the Western Cluster of Victoria and included questionnaires for consumers, clinicians and service providers. A series of workshops were held to seek the views of consumers, carers and clinicians on ROM and strategies were developed which informed the project direction.

As a result of the views expressed in this project, a number of strategies have been pursued to support sustainable implementation of ROM in mental health services:

- Education and training for clinicians co-facilitated by consumers and carers has been rolled out by the majority of services across the Western Cluster.
- A DVD was produced in association with AMHOCN (Australian Mental Health Outcomes and Classification Network) that explores the perspectives of consumers, carers and clinicians, which is now used nationally for training.
- New ‘user friendly’ promotional materials have been developed which were written in conjunction with consumers and carers.
- The project has gained national momentum and the team has presented this unique project to clinicians, consumers and carers in other states and territories in 2006 and New Zealand in October 2007.

Application of EQuIP Principles

Customer focus
- An emphasis on improving the clinical use of ROM for the benefit of the mental health consumer.
- Employment of a project team which included a consumer and a carer consultant.
- Funding for individual services to engage consumers and carers to be involved in the project.
- A range of workshops and collaborative activities to engage consumers and carers in the project.
- Training developed for consumer and carer consultants to prepare them to be involved in the training of clinicians.
Effective leadership
- Support for services to set up implementation groups and involvement of these groups in the steering committee.
- Positioning of project workers in participating agencies to encourage ownership of the project.

Continuous improvement
- Production of a DVD highlighting the views of consumers and carers about ROM which is used as part of the national training materials.
- Production of promotional materials highlighting the views of consumers and carers designed to raise awareness about ROM.
- Involvement of consumer and carer consultants in the training of clinicians in ROM.

Outcomes
- Evaluation showed increased involvement of consumers and carers in the ROM process and training.
- Services indicated an increase in compliance with ROM post project.
- Services indicated a commitment to the use of ROM in care planning, review and discharge.
- The evaluation showed that consumers, carers and clinicians were more interested in being involved in the ROM process after exposure to the promotional materials.

Striving for best practice
National recognition of the project through national distribution of materials and invitations to present the project at ROM forums in Queensland, Western Australia and New Zealand.

Innovation & Application to Other Settings
- The results of the project indicate that where support from Management and Medical Staff in the process of integration of ROM into clinical practice has been achieved, the greatest change is possible.
- The project has seen considerable momentum and commitment from Consumer and Carer Consultants to the ROM agenda. They clearly have a continued role to play in educating consumers and carers who enter their services of the potential benefits of ROM to the individual.
- The overwhelming lesson from the approach of bringing consumers, carers and clinicians together was the opportunity to model collaboration. Feedback from all parties involved indicated that this was a positive experience with consumers and carers indicating that the process had raised profiles in some services.
- There was a confidence built among all parties that collaboration can work and that the three parties can work together toward common goals.
Using Client Self-Report of Psychological Distress / Symptomatology to Improve the Effectiveness of Psychological Interventions
Greater Newcastle Cluster Hunter New England Health, GNC Psychology, Newcastle, NSW

Authors
Natalie McCall  Head of Discipline Psychology, GNC
Elizabeth Ditton  Clinical Psychologist, Eastlakes CHC

Aim
To increase the use of outcome measures in the initial therapy session by 50% and increase the routine (pre and ongoing) use of measures in therapy to 65%.

Abstract
In the absence of a consistent method for evaluating the effectiveness of therapy, a system of routine administration of standardised outcome measures was established. This system has been found to improve treatment success (Lueger 1998). A database was created to collate and analyse outcomes for the team collectively and individual psychologists. During the period under examination, the use of outcome measures in the initial session increased by 65% and the routine use of outcome measures increased from 37% to 59%. Furthermore, 56% to 58% of clients achieved statistically significant reduction in distress/symptomatology. GNC psychology is the only service that routinely uses outcome measures to monitor and analyse the effectiveness of therapy provided by individuals and the team. Integrating the outcome measures with CHIME would enhance the current system, facilitate wider use of this system across the Health Service and provide an avenue for benchmarking performance.

Application of EQuIP Principles

Customer focus
- client is involved, informed and an active participant in their treatment
- a clear picture of improvement, deterioration or no change is used to initiate and engage the client in a discussion regarding progress or lack thereof.

Effective leadership
Psychologists commitment was elicited through various mechanisms including use of regular feedback in relation to key performance indicators, the ability for each psychologist to access, evaluate and reflect upon the effectiveness of the therapy provided and recruitment based on willingness to use outcome measures routinely.

Continuous improvement
Usage of measures in therapy and the effectiveness of treatment can be monitored and benchmarked over time.

Outcomes
- 65% increase in the number of clients completing an outcome measure in the initial session and increased use of measures routinely in therapy from 37% to 59%
- 56.1% of clients achieved a significant reduction in symptom distress.

Striving for best practice
Evidence that this system is superior as routine use of outcome measures in therapy increases the likelihood of treatment success.
Innovation

- This is an innovative and dynamic project in that it required extensive research, substantial changes to work practices and willingness by psychologists to be accountable for the quality of care they provide.
- Traditionally psychologists have maintained the stance that clinical work is too complex to be measured quantitatively. Clearly the GNC psychology team has successfully moved beyond this belief and value the additional information quantitative evaluation can bring to therapy.
- Furthermore, psychologists have not previously had a system in place that would enable benchmarking against prior performance or the results outlined in the literature. GNC psychology have successfully designed a system that will enable future benchmarking with the view of continually striving to improve the quality of care provided to clients.

Applicability to Other Settings

- able to integrate outcome measures with established systems such as CHIME
- able to replicate into other systems
- basis of performance evaluation for both staff and customer
- benchmarking.
Well-tel: an Alternative Model of Care
Royal Perth Hospital, Rehabilitation & Orthopaedic, Shenton Park, WA

Author(s)
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Julia Reany Coordinator, Corporate Support

Aim
To provide an alternative model of rehabilitation care based on best practice principles.

Abstract
In June 2002 the Premier of Western Australia commissioned the Health Reform Implementation who recommended a medi hotel facility be established in conjunction with a tertiary hospital with an evaluation of its effectiveness undertaken.

Royal Perth Hospital, Shenton Park Campus had an alternative solution…Well-tel. A Well-tel can be best described as a hotel or hostel like environment providing accommodation to people who are undergoing or receiving rehabilitation or other services. Suitable accommodation already existed on the Shenton Park Campus of Royal Perth Hospital.

Although the division did not propose to close any beds as such, the model of care provided a more efficient alternative. Current in-patient costs are approximately $550 plus per bed day. It was suggested that a Well-Tel could function at a much lower cost per day taking into consideration accommodation receipts provided by the Patient Assisted Travel Scheme (PATS).

The Rehabilitation & Orthopaedic Division wish to continue this model of care into the development of the new State Rehabilitation Centre based and the proposed Fiona Stanley Hospital. Well-tel is managed by a multidisciplinary team that have contributed to the development of modification of the service to meet rehabilitation needs of our patients.

This model of care was proposed by staff within our Division. There is continuous monitoring to improve the service e.g. personal alarms, satisfaction surveys, feedback from staff and continuous monitoring of patient outcomes, activity and finances.

- Amputee LOS has decreased from 38 days in 2005/06 to 26 days in 2006/07.
- Neurology waitlists have decreased from 500 days in August 2006 to 54 in May 2007.
- 92% were satisfied with privacy in Well-tel compared to 77% in 2002 for a conventional ward.

We are the first rehabilitation service to offer this model of care. Others have established Medi-hotels for surgical procedures aimed at a different case mix. Well-tel patients are more appreciative, cheaper and “weller” than patients in our wards.

Application of EQuIP Principles

Consumer focus
These are some of the written comments received from our patients:
- Beneficial program, provided physical and emotional boost, opportunity to talk with other with same condition provided a clearer understanding of condition.
- Totally satisfied, all staff helpful and encouraging. Program really helped in knowing what to do and what not to.
• Absolutely brilliant way to be treat patients that are otherwise well and independent. This keeps us off the ward and provides a more positive way to do things. The set up is to be applauded.
• Well-Tel should stay open permanently to maintain the support, guidance and independence for those to follow, as it has given me the courage to find my feel again.
• The physio crew should be given awards for excellence. Without this Well-tel service I could not have got the treatment that was required, please keep this service going.
• Would be the most needed outfit at Shenton Park. PLEASE keep it going, people like me need this service so much. It is unheard of in rural areas. Please keep up the good.
• A Brilliant Idea.

Effective leadership
• The Well-tel is a new era in best practice fulfilling the objectives of the Reid Report. No other service provides this type of service in a rehabilitation care within Australia.
• This model of care is able to provide 10 beds at a cost (with 100% occupancy) of $70 per days as opposed to $550+ for a conventional hospital bed.

Continuous improvement
This model of care was proposed by staff within our Division. There is continuous monitoring to improve the service eg personal alarms, satisfaction surveys, feedback from staff and continuous monitoring of patient outcomes, activity and finances.

Outcomes
• Amputee LOS has decreased from 38 days in 2005/06 to 26 days in 2006/07.
• Neurology waitlists have decreased from 500 days in August 2006 to 54 in May 2007.
• 92% were satisfied with privacy in Well-tel compared to 77% in 2002 for a conventional ward.

Striving for best practice & Innovation
We are the first rehabilitation service to offer this model of care. Others have established Medi-hotels for surgical procedures aimed at a different case mix. Well-tel patients are more appreciative, cheaper and “weller” than our patients in our wards.

Applicability to Other Settings
Anywhere willing to try something different, take a risk and have an open mind
Category

Non-Clinical Service Delivery
WINNER
Cancer Patients’ Legal Assistance Program

A Partnership between Peter MacCallum Cancer Centre and Baker & McKenzie, Lawyers to provide pro bono legal services to cancer patients

Peter MacCallum Cancer Centre - Melbourne

AUTHOR
Elizabeth Ballinger, Head, Social Work Department

ABSTRACT
In 2005, in recognition of the barriers experienced by cancer patients in accessing expert legal services, the Social Work team at Peter Mac in partnership with Baker & McKenzie, Lawyers, established The Cancer Patients’ Legal Assistance Program. The aim of the program is to alleviate the financial, social and psychological burdens and distress associated with unmet legal needs. Following a needs analysis and scoping exercise, Baker & McKenzie undertook to provide, on a pro bono basis, legal services in the areas of:

- Early access to superannuation and/or income protection insurance*
- Deferral and forgiveness of HECS debts*
- Enduring and/or Medical Powers of Attorney*
- Social Security*
- Other matters on a case by case basis

Note:
*Legal aid is not available in any of these areas

The Australia-first program was evaluated in November 2006 after a 12 month period and has demonstrated substantial benefits for patients. Forty-five referrals generated 68 legal matters. The evaluation showed that the provision of these services was instrumental in alleviating financial, social and emotional distress. A patient recently (June 2007) wrote to Baker & McKenzie:

"I'd like to thank you again from the bottom of my heart for all your help. I'm feeling more positive now and am hoping my condition will improve for a while longer. Thanks again"

The program, now ongoing, has identified opportunities for further development. Significantly, identification of inequities in taxation laws relating to early access to superannuation has led to Baker & McKenzie taking on an advocacy role to effect changes to legislation in this area. Changes to existing laws would have the potential to benefit all people, nation wide, who are suffering from a life threatening illness.

INTRODUCTION

Peter MacCallum Cancer Centre (Peter Mac) provides medical treatment and supportive care to cancer patients from all over Victoria and beyond. Addressing practical concerns is vital in facilitating access to treatment and adjustment to the psychological and socio-economic impact of diagnosis. Many people require expert legal advice and services but may not know where to go to get help or have limited personal resources due to illness. Social workers at Peter Mac recognized that they had varying levels of success in assisting or referring patients for timely and appropriate legal advice and assistance in some areas of law. They anticipated that access to
free legal services through one referral source would provide much needed tangible legal outcomes and benefits and relieve the associated social and psychological demands.

Baker & McKenzie has served as pro bono lawyers to the Peter MacCallum Cancer Foundation since 2002. In 2005, in the spirit of corporate social responsibility, Baker & McKenzie agreed to explore, with the Social Work Department at Peter Mac, the possibility of developing services to meet some of the unmet legal needs of patients.

With the support of Peter Mac’s Chief Executive Officer, the Social Work Department joined with Baker & McKenzie to conduct an analysis of unmet legal needs. Based on this a proposal to establish a pilot program was approved by the Peter Mac Executive and the program was implemented in late 2005. The program was designed, developed and implemented under the leadership of the Chief Social Worker at Peter Mac and the Director, Pro Bono and Community Service, Baker & McKenzie.

The program was formally evaluated in November 2006 and has now been approved as an ongoing service. The Cancer Patients’ Legal Assistance program enhances supportive care to Peter Mac patients and their families and all services are provided within existing health care resources and with no additional funding.

The program has received much publicity in the press and was mentioned in the Victorian Parliamentary Debates, Members Statements, 14 June 2006, Hansard (attachments refer).

The Cancer Patients’ Legal Assistance Team

METHOD

The diagram overleaf, adapted from Alston & Bowles (1998) describes the cycle used to determine needs and to develop, implement and evaluate the program. It was recognised at the outset that successful development and implementation of the program required a change management process and engagement of all key stakeholders. Appropriate systems and review mechanisms were required to ensure an ongoing commitment from team members and continuous improvement in service provision.
A CONSUMER FOCUS - Pilot Scoping and Planning

In February 2005 a project group was formed under the leadership of the two organisations’ Team Leaders comprising key stakeholders from both organisations.

Research, including, a literature review, established that no similar program existed in Australia. It was determined that this innovation would be the first partnership to be formed in Australia between a hospital and a legal firm with the express goal of providing pro bono legal services for patients.

A survey (Needs Analysis) of all social workers and the Patient Advocate at Peter Mac explored the legal needs expressed to them by patients and their families and identified barriers to meeting specific needs.

Project scoping also took into account existing resources available to both cancer patients and health service providers. These include publications on legal matters such as Wills and Powers of Attorney and material written specifically for cancer patients, eg: Cancer: legal rights and responsibilities2. The scope of legal practice undertaken by Community Legal Centres was also acknowledged. The program did not seek to duplicate any of these services.

On completion of the investigation and scoping exercises, Baker & McKenzie undertook to provide services in the areas of:

- Early access to superannuation and/or income protection insurance*
- Deferral and forgiveness of HECS debts*
- Enduring and/or Medical Powers of Attorney*
- Social Security*
- Other matters on a case by case basis

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Note:
Legal aid is not available in any of these areas

EFFECTIVE LEADERSHIP - Implementation, Ongoing review and Continuous Improvement

Leadership and support was provided at the Executive level of both organisations, thus enabling Team Leaders in each organisation to engage stakeholders in a collaborative process of change and program development.

An Implementation Team was established, policies and procedures were written, referral processes and documents were developed. The Baker & McKenzie team comprises partners, senior and junior lawyers. Peter Mac’s team comprises all social workers and other key stakeholders.

Opportunities for continuous improvement were built into the review and feedback cycle. Regular feedback at team meetings enables us to analyse existing systems and processes and make adjustments as necessary or develop new processes and implement new strategies as required.

These include:

- Changes to written referrals to include additional information
- Updates to consent forms to facilitate timely information flow
- Joint interviews, facilitated by social workers, in some circumstances
- A training program for lawyers on medical terminology
- A debriefing strategy for lawyers
- Training for social workers in aspects of law, e.g., early access to superannuation, taxation laws

CONTINUOUS IMPROVEMENT - Evaluation

A formal evaluation was conducted in November 2006 using both qualitative and quantitative methods. The evaluation, following a 12 month period, involved:
• A review of records to determine the number and nature of legal matters addressed
• A survey of social workers to determine benefits to patients and families from their perspective
• Observations of Baker & McKenzie

A decision not to conduct a survey of patients/families at this early stage was made because many patients were extremely ill or had recently died.

The outcomes reported below are from the evaluation conducted in November 2006, covering the 12 month period. The program has continued from this time.

OUTCOMES
Legal Outcomes

Forty-five referrals were made by social workers at Peter Mac, generating 68 legal matters as follows:

<table>
<thead>
<tr>
<th>Area of Law</th>
<th>Number of Legal Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Access to Superannuation</td>
<td>29</td>
</tr>
<tr>
<td>Powers of Attorney</td>
<td>17</td>
</tr>
<tr>
<td>Wills</td>
<td>11</td>
</tr>
<tr>
<td>HECS</td>
<td>1</td>
</tr>
<tr>
<td>Income Protection Insurance</td>
<td>5</td>
</tr>
<tr>
<td>Unfair Dismissal</td>
<td>2</td>
</tr>
<tr>
<td>On referral</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>68</strong></td>
</tr>
</tbody>
</table>

Additional Services
In addition to the above, social workers regularly consulted with lawyers to assist in matters which did not need a formal referral.

While outside the scope of the program, Wills were completed in circumstances where the assigned lawyer assessed that this was urgent and necessary given individual circumstances.

Also outside the scope of the program, referrals in relation to unfair dismissal were accepted by Baker & McKenzie and other matters, outside of the scope of the program, were on referred for specialist legal advice.

Outcomes and Benefits for Patients and Families
A survey of all social workers by questionnaire was conducted. Questions asked were:

- What do you think have been the additional benefits that this service has provided to patients and families which were not in place previously?
- Have you noticed any changes in your social work practice as a result of the program?
- Has there been an impact on your workload?
- Other comments?
A qualitative method using thematic analysis was adopted to identify and code statements/words/expressions used by respondents in answer to the questions. These were then organised into dominant themes and categories.

Features highlighted in the responses by social workers are:

- Expertise of lawyers and their ability to address complex legal matters.
- Prompt, efficient and timely response, particularly in urgent situations.
- Flexibility – services are provided at the convenience of, and at the best location for, patients (Inpatient Wards, Social Work Department, Baker & McKenzie Offices, satellite centres).
- Lawyers have developed an understanding of the financial, social, physical and emotional impact of a cancer diagnosis on patients and their families.
- Provision of legal services has alleviated distress and burden, including financial burden.

Example
A typical example of the benefit of expert intervention from the legal team, and the relief of burden, for patients is highlighted by a situation outlined by a social worker. After trying for 14 weeks to access superannuation for Con, a 21 year old terminally ill patient, to enable him to address financial concerns, including palliative care, the social worker had made no progress. Following a referral to Baker & McKenzie a payout was made in seven days.

Social Workers said:

“Access to speedy and efficient legal assistance at no cost to the patient has meant less anxiety and stress for patients and their families at an already stressful time.”

“T\ have received very positive feedback from the patients and families who have accessed the services ….”

“The relief that we see on patients’ faces when offering [legal] services is priceless … allowing patients to concentrate on their health and treatment for cancer”

[from a patient] “I am really thankful for all the help you have given me. My wife will be looked after now and the house will be paid off so she will manage”.

Outcomes - Therapeutic Benefit
Some patients are extremely distressed by situations which can only be relieved by legal intervention. After providing these services, some patients have been able to address the existential issues which arise when faced with a life threatening illness. We have termed this a “therapeutic benefit” highlighted by the plight of 42 year old Michael who was diagnosed with terminal cancer and unable to work.

Example
Michael and his wife (who also had to stop work to care for him) had two young children and a large mortgage on a home purchased when he thought he had many years ahead of him. Michael’s distress over the prospect of losing the home and the impact that this would have on his family was so great that he was unable to engage with health care.

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4 Not his real name
5 Not his real name
professionals. Michael had been trying unsuccessfully to access his superannuation and he was skeptical that his social worker could help. However, after a referral to Baker & McKenzie resulted in a payout within two weeks, he was able to focus his energy into planning his family’s future and addressing his psychological needs.

Outcomes - Change in social work practice
Social workers reported significant changes in practice which continue to improve and expand supportive care to patients. They reported an increase in knowledge, skills and confidence in addressing legal issues. Less experienced social workers indicated that they are now more likely to raise sensitive legal issues in routine assessments.

“I have definitely felt more confident and comfortable raising and discussing issues with patient/families…..Having a greater working knowledge of super funds and the "fine print" that a legal professional can clarify has been fantastic.”

“I feel more confident discussing the difficult/challenging issues raised, knowing that a legal professional is available to assist/consult/advocate/ follow through.”

“It [the program] has enabled a stronger bargaining position when advocating for patients with superannuation funds.”

Impact on Workload
Social workers reported that any increase in workload is balanced by enhanced services to patients and families. The program has been a positive experience for all team participants who have reported substantial learning, and increased knowledge of the work and value of both professions in providing care for cancer patients and their families.

SUSTAINABILITY
At Peter Mac
The Peter Mac Executive approved the Evaluation Report’s recommendations and the program is now an ongoing service for Peter Mac patients.

A Model for other Health Care Providers (national and international)
The model is applicable to other settings. The program has been presented at national and international Law and Social Work conferences where the model has been distributed to, and discussed with, interested professionals from law firms and health care providers. It will also be presented at the 5th Australasian Conference on Safety and Quality in Health Care in Brisbane in August 2007. An opportunity to discuss the program with international partners of Baker & McKenzie and health care providers will be taken up in October 2007 when the International Bar Association meets in Singapore.

COSTS AND RESOURCES
The program is delivered within existing resources at Peter Mac. The evaluation demonstrated that staffing resources invested were balanced by the reduction in workload resulting from the legal services provided and the increase in knowledge and skill of social workers.

Baker & McKenzie provide all services on a pro bono basis.

CONTINUOUS IMPROVEMENT
Law Reform
An example of program expansion and development which demonstrate best practice and the adoption of continuous improvement principles is provided by the law reform agenda adopted
during the pilot period. Due to the high number of referrals for early access to superannuation the lawyers of Baker & McKenzie developed specialised knowledge and expertise in this area. This led to the identification of unreasonable disadvantage for people with life threatening illness in existing and proposed laws relating to the taxation of superannuation benefits. A submission to the Commonwealth Treasury was prepared in response to the Commonwealth Government’s Plan to Simplify and Streamline Superannuation, highlighting a serious inequity faced by the terminally and seriously ill in relation to the taxation of their superannuation entitlements. Baker & McKenzie continue to advocate for change in this area of law. This unanticipated benefit has the potential to benefit people Australia-wide.

CONCLUSION
Evaluation of the The Cancer Patients’ Legal Service has demonstrated that the program is consumer focussed and has been successful in meeting its aim to alleviate financial and social burdens and the psychological distress associated with serious illness. The model designed to implement the program has been successful in facilitating continuous improvement and service expansion to accommodate the emerging needs of patients and families. The learning gained during the implementation of this program has demonstrated the potential to benefit the wider community through its role in advocating for change in taxation laws relating to early access to superannuation. The model has been widely publicised and can be replicated or adapted by other organisations.

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Maurice Blackburn Cashman in conjunction with The Cancer Council Victoria, 2004. Cancer legal rights and responsibilities, Publicity Works MAUB 23337


Ms MIKAKOS (Jika Jika)—On 25 May I had the privilege of launching a unique new pro bono legal clinic for the Peter MacCallum Cancer Centre at the offices of lawyers Baker and McKenzie. This cancer patients' legal clinic will provide free legal advice to those suffering from cancer, people for whom the added burden of legal fees may just be too much. The involvement of Baker and McKenzie in the cancer patients' legal clinic demonstrates that lawyers are willing to make the most of their abilities and respond to the community and those in need.

The cancer patients' legal clinic is the first of its kind anywhere in the world and is an innovative and reasoned approach to the problems that beset cancer sufferers and their families. I applaud Baker and McKenzie for its work with the world-renowned Peter Mac and hope this innovative approach to the provision of pro bono assistance will set a precedent for more of its kind throughout Australia and the world.
Pro bono goes medical

A law firm and Peter Mac have established an Australian first – a cancer patients legal clinic.

The Peter Mac Cancer Patients Legal Clinic is the first of its kind in Australia, and represents a calculated step to an often overlooked area of legal need – it was officially opened in May this year and is the result of a partnership between the Peter MacCallum Cancer Foundation and Melbourne law firm Baker & McKenzie.

While most of us would not associate cancer with legal issues, a number of financial and administrative concerns can arise for people diagnosed with the illness. In particular, patients often require assistance in areas such as taxation, powers of attorney, and estate planning. Finding the energy and time to deal with these affairs can be extremely stressful for patients and their families, who are already burdened with profound emotional, physical and financial strains related to the cancer diagnosis and treatment.

In March this year, a study published by the NSW Law Society and Justice Foundations on access to justice and legal needs in NSW noted that the development of funded legal aid services for people with chronic illness or disability as a top priority. The report, entitled 'Justice for All: More Justice for People with Chronic Illness or Disability', noted that people suffering from a chronic illness had a significantly higher incidence of a wide range of civil, criminal and family legal events than the general population, with poor rates of satisfactory resolution.

The Peter Mac legal clinic is an innovative response to this problem. First conceived in 2002, the clinic emerged from an existing pro bono relationship between the Cancer Foundation and Baker & McKenzie. Jennifer McVicar, director of the first Pro Bono and Community Service program, says that the team of legal professionals involved in the program.

"We are delighted with the benefits of this program,” McVicar says. “Our clients have found the service to be invaluable in assisting them in their legal needs and the clinic provides an opportunity for our firm to assist those who may not otherwise have access to legal advice. We are proud to be able to make a difference in the lives of these patients and their families.”

"The clinic provides a much-needed service for people with cancer and their families, who are often faced with complex legal issues,” says Cancer Foundation CEO Dr John Crompton. “The clinic allows them to focus on their medical needs, while accessing legal advice and support. This is a significant step forward in ensuring that all cancer patients have access to the legal advice they need.”

The clinic offers assistance to cancer patients and their families in a range of legal areas, including wills and estates, guardianship, and medical and clinical negligence.

Looking to help?

To facilitate access to a broader population of cancer patients, the clinic has also developed a branded campaign to raise awareness of the service. The campaign includes a series of workshops and seminars, as well as a website and social media presence.

Current needs of group

"ACCC is looking for people who are passionate about making a difference to the lives of cancer patients and their families," says ACCC CEO Alyson MacLachlan. "The clinic is a fantastic opportunity for those who want to make a difference and help improve the quality of life for others."
Cancer patients' Legal Assistance Program

Peter MacCallum Cancer Centre in Partnership with Baker & McKenzie, Lawyers

Cancer patients get boost for financial survival

Lawyers and social workers have joined forces in a unique service for Peter MacCallum cancer patients, reports Amanda Place.

The Cancer Patients’ Legal Assistance Program (CALAP) aims to improve access to legal services for cancer patients in Victoria. The partnership between the Peter MacCallum Cancer Centre and Baker & McKenzie, a global law firm, was officially launched in March 2007.

“CALAP is designed to ensure that cancer patients have access to high-quality legal advice and representation as they navigate the complex maze of legal issues that can arise during and after their illness,” says Mr. Robert Fink, CEO of the Peter MacCallum Cancer Centre.

“CALAP will provide legal assistance to patients facing issues such as: medical negligence, workplace injury, superannuation, as well as other legal matters that may arise as a consequence of being diagnosed with cancer,” according to Mr. Fink.

“The program is unique in that it links cancer patients with an experienced legal team who understand the specific needs of people with cancer,” Mr. Fink added.

The program operates on a sliding scale fee arrangement, with patients paying a contribution toward their legal representation, based on their financial circumstances. This fee is capped at $200.

The program is run by Baker & McKenzie’s Melbourne office, which has dedicated a team of lawyer and paralegals to the program. The team is supported by the Centre’s social workers.

The program is part of the Centre’s broader commitment to improving the quality of life for cancer patients, and to ensuring that they have access to the support and resources they need to manage the challenges of living with cancer.

For more information, please visit the Peter MacCallum Cancer Centre website: www.maccallum.org.au

Patients advice

More information on the overcharge and return process is available on our website: national.com.au

Barrister Ross

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Herald Sun 26/5/06
Grave concerns for sick super tax

By Michelle Innes

Lawyers from Baker & McKenzie are lobbying the government to wipe out tax on superannuation received early to those with a terminal illness. In a submission to Federal Treasury, Ken Gray says the terminally ill and others with life-threatening illnesses are treated unfairly under existing laws relating to tax on super.

The laws increase the financial stress on the seriously sick, and hamper their ability to get their financial affairs in order before they die, he says. Gray and Jennifer McVice, Baker & McKenzie’s directors of private wealth and community services, wrote a team of lawyers who provide legal advice to patients at Melbourne’s Peter MacCallum Cancer Centre. Gray, a partner, is in charge of cancer patients’ legal services.

The lawyers say that about 50 per cent of the people they work with at the Peter MacCallum Centre, a public health centre, die from their illness. “Our clients are in personal, social and economic crises,” the submission says. “They are from all ages, backgrounds, nationalities and walks of life, as cancer does not discriminate. Many have young families.”

The inequities in the super system mean that super paid to a dependant after death is tax-free but the same benefit received before death is taxed.

“The people we are dealing with have small amounts of money in super,” McVice told Money. “And they don’t work on the early release of those funds for fun. It’s because they are facing extreme hardship. They are struggling to come to terms with their diagnosis and they may also be facing eviction with the loss of their home.”

The submission states that most of the clients the lawyers help have “entitlements of only a few thousand dollars to a maximum of $50,000 or so. Access to super represents the best chance our clients have of bringing some semblance of financial order to their lives, to pay for medical costs and transportation, to meet at least some of their debts and alleviate pressure from creditors.”

“The Australian Prudential Regulation Authority will release super funds early in cases of extreme financial hardship. Conditions for the early release of savings may include the investor having received Government income support payments for 26 consecutive weeks, or being able to prove that he or she is unable to meet maintainable and immediate family living expenses.”

An authority spokesman says it decides whether a request for the early release of super meets the grounds set out in legislation but the super fund trustee makes the final decision on whether super funds are released.

That decision depends on the individual’s circumstances. How that money is taxed is a matter for Federal Treasury and the Australian Taxation Office, the spokesman says. Gray’s submission states that super is partly taxed if it is released because the recipient is temporarily or permanently disabled, and wholly taxed if the benefits are related on the grounds that the recipient is facing financial hardship or on compassionate grounds.

Treasury considered the Baker & McKenzie proposal as part of its recent Fisheye Super reforms, which take effect on July 1, but in the end did not adopt the proposal.

McVice says the complexity of the super system means that the tax rate varies for each investor but, as a broad rule of thumb, most of their clients pay 10 to 30 per cent tax, depending on their circumstances.

The Government’s recent reforms to super mean that those aged more than 60 will pay no tax, and no reasonable benefit limits apply. “Although these persons are not 60, in some cases they are living the only retirement they will ever have,” the submission states.

McVice says all of the patients the lawyers help have withdrawn their super early and paid the tax because they needed the money. “None have left the money to their estates, when it would be released tax free.”

“People in that situation have immediate financial needs. They want to settle their debts and get their affairs in order before they die, rather than leave that to their families.”

The submission also states that removing the tax on early release super would have a marginal impact on Government revenue. It says changing the law will not have a material impact on government revenue as the tax can be avoided simply by having the money in the super fund to be accessed after death by the dependants. It says few people meet the conditions for the early release of their super.
Submissions Non-Clinical Service Delivery

Aboriginal Health Service Development and Partnerships
Southern Health, Quality Unit, Clayton South, VIC

Author
Kari Hawke
Acting Program Manager Aboriginal Health, Greater Dandenong
Community Health Service, Southern Health

Aim
To improve access to mainstream health services for Aboriginals and Torres Strait Islanders (ATSI).

Abstract
Steering committees, management groups and working parties were established to oversee the community-based Aboriginal focused programs and projects from mid-2006, and service models were developed by the end of the year, with the establishment of the Southern Health Aboriginal Partnership Committee.

Strategies were developed to provide culturally receptive environments for Aboriginal clients at community health service sites in Greater Dandenong and Casey. Southern Health, DDACL and Chisholm Institute worked with local artists to create artwork for sites frequented by Aboriginal clients. More than 20 artworks by Aboriginal artists and a photographic display have been purchased or commissioned.

Compatible client information management systems were developed across Southern Health community-based Aboriginal focused programs and projects.

Formal local training opportunities for Southern Health Aboriginal staff were established through partnerships with consultants and Chisholm Institute in April 2007 and some staff are now undertaking work modules to complete their Aboriginal Health Worker Training Certificates.

The Southern Health Aboriginal Partnership Committee oversees and supports a collaborative approach to the ongoing management and co-ordination of issues that could contribute to the enhancement of the Aboriginal focused programs, projects and initiatives. A Southern Health Aboriginal Staff Group was established to address staff support and identify issues.

Application of EQuIP Principles

Customer focus
The partnership vision statement (included in the Full Report), is completely focused on the consumer - the Indigenous community. The overall goal is to improve the health status of Aboriginal people, through strategies including:
- greater awareness of Indigenous culture and health issues by service providers, and better service delivery by community health services and general practitioners
- reduction in repeat admissions for diabetes complications in Aboriginal people
- strengthened collaborative relationships between Aboriginal groups and Aboriginal organisations, community health services and other relevant service providers
- increased capacity of the Aboriginal workforce and Aboriginal community in health service planning and delivery for Aboriginal communities
• consumer surveys to help the partners understand the Aboriginal community’s view on current health needs and priorities.

**Effective leadership**
Communication and trust has continued to strengthen since formalising partnership arrangements. The honest approach addressing complex cultural and service delivery issues – aiming for better services – has been a significant step. Leadership principles used include:

- a collaborative approach to program development
- strong working relationships between all staff levels at partnering agencies
- acknowledgment of ATSI cultural influences
- acknowledgement of the importance of ATSI community support and involvement
- support and endorsement of organisational change management strategies at senior management and Board of Management levels within all agencies.

**Continuous improvement**
The DDACL and Southern Health have concentrated on continually improving collaborative service structures, sharing experiences and achieving service improvements through:

- supporting each other on staff management responsibilities across agencies
- sharing staff and in kind efforts across the programs and agencies as needed
- staff working more closely with the partnership to address priority needs
- working on compatible client information systems across Southern Health to better understand Aboriginal client access and engagement.

Work is due to soon begin to identify opportunities and links between the different client information management systems.

**Striving for best practice**

- The partnership continually reviews and addresses issues for the local Aboriginal community, as well as informing the Southern Health Aboriginal Partnership Committee.
- All programs and projects have evaluation components within their planning and development.
- Community engagement is continually encouraged to address community ownership and participation.

**Innovation**
The entire project is based on the fundamental approach to a strong and sustainable relationship about listening and adapting each agency’s practices and procedures to jointly support the Aboriginal community.

**Applicability to Other Settings**
This partnership project is believed to be the first of its kind in Victoria, so there has been no real opportunity to learn from others or apply standard best practice. Despite the lack of precedents, the agencies are confident of success and believe the initiative could be adopted by others with similar objectives in the field of Aboriginal health, both at Southern Health and other organisations.
An Integrated, Online, Credentialling and Defining Scope of Clinical Practice System for Senior Medical Staff
Southern Health, Quality Unit, Clayton South, VIC

Author(s)
Workforce Planning and Development Team, Human Resources:
Kyla Evans
Bridget O’Brien
Sarah Harper

Aim
To develop and implement a comprehensive, integrated, online senior medical staff credentialling and defining scope of clinical practice system, including protocols, tools and processes to ensure the appropriate registration, credentialling and defined scope of clinical practice for all senior medical staff.

Abstract
Methodology
The Southern Health Board of Directors and the Executive Management Team identified the need for a quantum improvement in existing clinical governance systems, especially as they related to senior medical staff credentialling and defining scope of clinical practice processes. These groups, along with the Medical Executive, maintained ownership, active participation, and leadership of the project to establish an integrated credentialling process.

Research into world’s best practice on clinical governance issues provided the foundation for the development and implementation of the system, tools, and processes. A project team (including Human Resources and the Chief Medical Officer) planned, coordinated, managed and evaluated the project. Leadership was shared by the Executive Director Human Resources and the Executive Director Medical Services (Chief Medical Officer).

Outcomes
• The development and implementation of a flexible, customisable, web-based Credentialling and Defining Scope of Clinical Practice system (known as MedCred), and supporting processes.
• 717 senior medical staff (91%) have so far participated in the MedCred process.
• Greatly enhanced relationships between senior medical staff and Human Resources.
• Existing MedCred processes for senior medical staff were reviewed.
• Increased acceptance by stakeholders of the need for a robust MedCred system.

Application of EQuIP Principles
Customer focus
There are three distinct customers in this project:
• Patients: the first priority and the ultimate beneficiaries as quality of care is better ensured by confirming the appropriateness of staff qualifications and scope of clinical practice.
• Senior medical staff: it was important to develop a user-friendly, efficient, and clinically specific system that met their needs.
• Southern Health: MedCred greatly minimises the risk of employing, or continuing to employ, senior medical staff who are not registered or not appropriately qualified or credentialled for the work they are undertaking, thereby enhancing clinical governance.
**Effective leadership**
The project is actively led as a joint venture between the Medical Executive and Human Resources. Committees were established to ensure the project progresses effectively, including a Credentialling and Scope of Practice Committee, a Medical Executive Credentialling Sub Committee, and a Human Resources project team. These groups each have different, well defined roles and responsibilities, which combine to ensure the project is led comprehensively and efficiently. Underpinning the work of the committees are appropriate policies and procedures to support the project and its ongoing success.

**Continuous improvement**
From the outset, the aim was to continually improve and develop the MedCred processes. Extensive lead time was invested into developing the various elements to ensure planning and development was thorough and comprehensive.

An initial pilot of the tools and procedures helped the process move forward. Rollout to the greater senior medical staff group was quite fluid, with changes to the process occurring as needed. After about half the applications for MedCred were received, an evaluation, including an online survey and focus groups, identified the potential for improvement, helping ensure full senior medical staff participation. Appropriate measures and indicators for success were determined, are monitored and evaluated - largely online. The results provide a measure for future improvements.

**Outcomes**
One of the most encouraging outcomes so far has been the support and engagement of the project by the senior medical staff themselves. The Medical Executive has also supported the project and has been a key driving force behind its success. This has strengthened relationships and collaboration between these two groups.

Other outcomes include the development of a comprehensive online system to manage the MedCred process from senior medical staff application through to Medical Executive authorisation; approaching full participation by senior medical staff; greater awareness and acceptance of the need for such a process in the organisation; and finally, the ultimate outcome is the improvement of quality of care and service to Southern Health’s patients and clients.

**Striving for best practice**
Extensive international and national research before the project began showed that MedCred for senior medical staff is a key clinical governance issue that faces all health care organisations. The success to which current systems address the issue varies widely. The Southern Health system offers many advantages over previous MedCred systems, and is at the forefront of best practice. Consequently, progress has attracted considerable interest and is being monitored within the field.

**Innovation**
The development and implementation of a robust senior medical staff MedCred system is truly cutting-edge. Our system offers the following over conventional credentialling methods:

- A purpose built software program, providing easy access to clinically specific, relevant tools.
- A central, secure, database that enables instant access to information and improves organisational efficiency.
- A supporting policy that has been ratified by the Board.

**Applicability to Other Settings**
Internally, the MedCred system has definite application within other health profession groups, for example, allied health and nursing. At Southern Health this is planned for Stage 2 of the project, including modification for these professions. With the increasing emphasis on health care providers to ensure the practitioners they employ are appropriately qualified and experienced, the outcomes of MedCred can undoubtedly be reproduced in other health care organisations.
Area Governance Manual
South Eastern Sydney Illawarra Area Health Service, Executive Support Unit, NSW

Author(s)
Ms Nel Buttenshaw, Director Office of the Chief Executive
Ms Rose Gavin, Manager Systems Integration (retired)
Ms Veronika Romankin-Arndt, manager Executive Correspondence Unit

Aim
The Corporate governance and accountability compendium for NSW Health (December 2005) sets out the roles and accountabilities of agencies that constitute NSW Health. As an Area Health Service, South Eastern Sydney Illawarra Health (SESIH) is required to comply with the Compendium as well as meet a number of statutory, legal, professional and accreditation standards and policy directives issued by NSW Health. This manual describes the Area's governance framework and the structure and systems that have been implemented within our health service to comply with the above requirements.

Abstract
The South Eastern Sydney and Illawarra Area Health Service's (SESIH) Area Governance Manual is the overarching Area framework to assist the health service in meeting its governance requirements.

The Manual was developed by means of a consultative process involving the portfolios of all Area Executive Directors, and it documents the roles, relationships and accountabilities of the Area Health Service Chief Executive, and the Area structures and processes that enable them to be achieved. The Manual is a living document that is available for staff to access via the Area's Intranet

SESIH is committed to excellence in both corporate and clinical governance and have put in place a strong governance framework to ensure that such excellence is delivered. This Manual describes the Area's governance system, and the relationships it has with overarching legislation, standards and guidelines to which we must adhere, together with our local policies, procedures and guidelines that provide us with the practical means to realise these requirements.

In order to provide quality health services, we must ensure not only that we have quality systems and structures in place, but also that our staff are committed to embracing our organisational values and objectives and to utilising the tools available to assist them.

This Manual provides such a tool for our staff to guide them through the complex web of governance requirements that support our quest for quality, and to direct them to the relevant Area documents and structures to undertake their necessary tasks.

Application of EQuIP principles, evaluation process, effectiveness, sustainability, innovation and applicability to other settings:

The Area Governance System is the system put in place by our health service to support the requirements and functions of the governance framework. The responsibilities, authority and accountabilities of staff that manage and perform work crucial to the quality outcome are detailed within our Area Policy Directives for Clinical Streams and Area-wide Functions, and within Hospital, Service and Departmental Procedures.
The Governance System is a “seven-tier” approach that commences with the corporate governance structure:-

**Tier 1: Corporate Governance**
Tier 1 of the Area Governance System details the organisational structure, committee structure, strategic and corporate plans and subsequent Area Enabling Plans.

**Tier 2: Corporate and Clinical Governance policy directives**
This section describes the key leadership corporate governance policy directives for our organisation that not only ensure we meet our statutory, legal and accreditation obligations but also provide direction to the Hospital Networks, Clinical Streams and Area-wide Support Services. The clinical governance policy directives ensure systems for monitoring patient care in response to the NSW Health Patient Safety and Clinical Quality Program and relevant ACHS EQuIP Standards.

**Tier 3: Area Clinical and Clinical Streams policy directives**
Tier 3 provides the documented clinical procedures to assist staff in the provision of patient care relating to specific Area-wide clinical streams as developed by representative stakeholder groups and approved by the Clinical Council. These documents are maintained within the Area Clinical Governance website.

**Tier 4: Area Support Services policy directives**
Tier 4 provides the documented area support services policy directives. The Area Policy Directive – Document control details the executive sponsor of Area Services Policy Directives. The Custodian must be informed of any changes identified to an existing policy and/or the need for a new policy. Both custodian and executive sponsor approve any changes to policies.

**Tier 5: Network Hospitals – Governance and policy directives**
The Area Policy Directive – Leadership and management details the responsibilities of sites and services for the management of local policies and procedures. Site procedures reference Area Policy Directives and are developed to take into account local circumstances.

**Tier 6: Departmental procedures and safe work practices**
The managers of departments/units ensure that there are formats and approval processes for departmental procedures (work instructions) and safe work practices. These documents follow standard document control principles and are maintained by department managers.

**Tier 7: Records – evidence of compliance**
Tier 7 relates to the records that show evidence of compliance to the requirements of the Area Governance System. Tier 1 of the system details our structural framework, Tier 2 our policy commitments, Tiers 3, 4, 5 and 6 translate the “5 W’s” of procedural requirements (what, where, when, who, why) and how these processes will be managed at Area and Site/Service level with Tier 7 providing the evidence that supports these quality commitments.

**Review of the Area governance system**
Regular monitoring and review of the effectiveness of the Area Governance System is managed by Compliance Audits that are aligned to Area Policy Directives. Each Hospital, Area Service and Facility is required to conduct an audit of the Governance System using the Area Compliance Tool at least annually. The Area Policy Directive – Audits: Area Management System details the role of the auditor in relation to their responsibilities for conducting and reporting audit results.
AUSLAB Pathology Project
Royal Brisbane & Women's Hospital, Health Information Services, Herston, QLD

Author(s)
Nicole Mair Director Health Information Services

Aim
To reduce the unmanageable number of pathology reports required for filing within the patient record and to ensure the record contains all relevant and timely information through prioritisation of pathology results and elimination of superfluous filing of results.

Abstract
In 2006, a new policy and procedure was introduced regarding AUSLAB pathology filing within patient records. This policy essentially eliminates the requirement for administrative staff to file “non priority” AUSLAB Pathology reports within the patient record unless the medical officer specifically requires this to occur.

As a result of the project, all AUSLAB pathology reports are now printed with an indicator box in the bottom right hand corner of the page. In the case of established “priority” filing such as histopathology, cytology and anatomical pathology, this box is automatically crossed “✓” when printed and therefore must be filed in the patient record.

For general AUSLAB pathology such as chemical pathology, microbiology and haematology, the medical officer must clearly cross “✗” the box [Indicated as “Tick or cross box to file in patient’s record”] if it is required that the pathology report be filed within the patient record. This may occur when the results are of particular significance or importance; otherwise these results are readily available on-line within AUSLAB.

All medical officers remain responsible for reviewing AUSLAB pathology results ordered by them for the patients in their care. However, this new process supersedes the requirement that all pathology reports must be signed by the medical officer. If the report is signed but not of priority, it is archived within Medical Record Department to satisfy legal requirements, otherwise AUSLAB pathology results not required for filing in the patient record may be confidentially destroyed following review of results.

A detailed policy was developed and implemented via the Patient Record Committee, and compliance with the policy is continually monitored through return of pathology results to wards and the amount of filing received in the Medical Records Department. (See attached Policy).

Application of EQuIP Principles
This project successfully applied EQuIP criteria 1.1.8 The health record ensures comprehensive and accurate information is recorded and used in care delivery.

Outcomes
The outcomes of this project are:

- all priority pathology results and correspondence are being filed in the patient’s record during the patient’s episode of care, or within 48 hours
- 82% decrease in outstanding pathology filing
- consistency in the approach to medical officers reviewing and verifying pathology results ordered; and
• decreased bulk of patient records which enables more storage space within the filing area.

![Graph of pathology reports versus time]

**Customer focus**
- prioritises filing of important results for timely patient care
- eliminates duplicate reports and unnecessary bulk within the patient record resulting in patient records which are easier to read and manage
- makes appropriate use of electronic information systems available; and
- increased staff satisfaction within the Medical Records Department with more task variety and reduction of outstanding pathology filing tasks.

**Effective leadership**
Time and resources consumed in the filing of pathology results has been a long standing, insurmountable issue for many years. In the absence of a suitable corporate system to verify electronic results, little initiative has been previously encouraged to address this issue. It is a national problem based on inability to make rational decisions regarding the “legalities” of this process while weighing up the benefits and risks. With careful planning, legal advice and common sense, RBWH has addressed the problem while satisfying all medical and legal requirements.

**Continuous improvement**
Several projects to reduce the burden of excessive pathology filing have been attempted over the past 7 years, a few of which made minor improvement. These improvements were quickly overshadowed by increasing pathology testing practices and patient load. Although electronic results reporting and verification (and electronic records per se) is the utopia, this process has dramatically improved arduous and superfluous processes regarding the verification and management of pathology results while retaining all patient safety aspects inherent in the previous system.

**Striving for best practice**
Extensive liaison with other hospitals both interstate and within QLD revealed all hospitals continued to struggle with the pathology filing problem with no perceived insight into how it could be improved. We believe we have achieved a best practice benchmark for reduction of pathology filing within a paper based medical record environment.

**Innovation**
An e-mail received from a colleague in Rockhampton says it all:

> Hi Nicole,
> Thanks for the info, it sooo refreshing to find people who are prepared to grab an issue 'by the horns' and deal with it rather than placing it in the 'too hard basket' - full marks to you and the RBWH crew! I just wish we could get QH to tackle this issue corporately and save us in the districts from 'reinventing the wheel' on this problem.
Sorting out the pathology filing will be the greatest breakthrough (HIM wise) in modern medicine since penicillin!

Thanks again for all your assistance on this issue, I'll let you know what finally comes to pass at Rocky.

Cam

Applicability to Other Settings
Several other hospitals have already adopted this innovative and long overdue method of filing and verification of pathology filing, and other hospitals are also encouraged to realise the benefits.
Cleaning Project
Northside, Northside West and Northside Cremorne Clinics, Greenwich, NSW

Author
Therese Poland, RN

Aim
In line with hospital renovations, the hospital CEO appointed an Infection Control Coordinator to review hospital cleanliness and address shortfalls. The aim was to identify and assess the existing cleanliness standard, determine a benchmark standard, and implement strategies to improve cleanliness. The assessment and intervention was undertaken between March 2006 and October 2006.

Abstract
METHODOLOGY: Research for best practice was undertaken with a focus on cleaner accountability, cleaning method and cleaning ergonomics. Audits were conducted in a total of nine wards across the three hospitals and comparison of data showed significant differences in cleaning standards and cleaning methods. This led to the development of an aggressive plan which involved restructure of services, re-design of cleaning tasks, purchase of new equipment and specific infection control training for cleaning staff.

OUTCOMES: Research revealed the need for new technology. The implementation of new technology revealed an improvement in hospital cleanliness. The overall results of the audit demonstrated a progressive improvement in the hygiene of the hospital environment. Patient satisfaction surveys and staff feedback revealed an improvement in the cleanliness of bedroom and unit areas.

Application of EQuIP Principles

Consumer focus
Hospital cleaning was monitored in a variety of ways. An in-house “Tell us what you think survey” aimed to determine the average level of satisfaction with the cleanliness of wards. A specific survey was developed to assess staff and patient perceptions and expectations. The three main areas for improvement which were identified as a major focus for the cleaning project were Cleaner accountability, cleaning method and cleaning ergonomics.

Effective leadership
- The cleaning project was itemed in each hospitals strategic plan and adopted by the Hospital Executive Committee, whereby an operation plan was developed and then implemented with the launch of a ‘Think Clean Week’ Campaign in month three and six.
- To address cleaner accountability, cleaners were allocated to wards under the direct leadership of the unit manager.
- Cleaning method was reviewed jointly with cleaners and unit managers during this process. Lists were written detailing location, task, instruction, chemical and equipment to be used. Atomisers were removed from chemical dispensers and replaced with flip top lids. Microfibre cloths were purchased for cleaning mirrors and windows, removing the need for chemical window cleaner. The bucketless mop system with microfibre head was implemented in lieu of the conventional wet loop mop and bucket.
- This also addressed cleaning ergonomics with the additional purchase of new trolleys and microfibre cloths. Staff received onsite training on new equipment and supervision throughout the implementation.
Continuous improvement

- **Evaluation** of the new cleaning system demonstrated an improvement in hospital cleaning and overall consumer satisfaction as evidence by audits, patient satisfaction and feedback reports.
- **Cleaner accountability** had improved, with unit managers participating in performance appraisals and providing on-going feedback about cleanliness. Cleaners reported an increase in job satisfaction and a reduction in workplace stress once they were familiar with the new system. Press Ganey survey results for 2006 revealed a 2.8% increase in patient satisfaction with cleanliness compared to the 2005 survey.
- Evaluation of **cleaning method** revealed cleaners were satisfied with detailed task and method description. Relief cleaners also reported having a clear expectation of duties enabled them to complete work. Throughout the three month trial of new equipment, risk data revealed there were no slips, trips or falls on bathroom floors. Chemical use review demonstrates a reduction in chemicals going down the drain.
- Evaluation of **cleaning ergonomics** verified that implementation was initially met with some resistance although this improved over time. Gradually over the three month trial period, Unit Managers reported cleaners applying correct techniques and cleaners reported ease of use of equipment and minimal to no back pain at the end of each day.

Outcomes

- Internal audits demonstrate an improvement from pre to post implementation. Pre-implementation scores fluctuated around the same value. Post implementation audit scores demonstrate a considerable improvement in hospital cleanliness. Several factors may have influenced this improvement including accountability, support and supervision, owners and new equipment to make the job easier.
- **Feedback** was an integral aspect of the cleaning project from conception through to evaluation and entailed communication via surveys, memorandums, think clean week, patient meetings and departmental meetings. Patients continued to provide feedback through in-house ‘Tell us what you think’ surveys and staff provided feedback directly to cleaners and management.

Striving for best practice

- The search for best practice led to innovation in cleaning and an overall improvement in cleaning practice.
- Creating the audit tool and assessing the cleanliness of each ward, created an energy of enthusiasm, as each cleaner anticipated notification of each months audit as the audit would reveal where they were sitting in relation to the new benchmark.
- The new cleaning system also received an honourable mention for the sustainability award from local council.

Innovation

- **Cleaner accountability** - research conducted by National Health Service United Kingdom (NHS, UK) (2006) recommends that allocating cleaners to wards established accountability and gave cleaners a sense of ownership, thus empowering them to perform and helping them to feel supported and valued as a team member.
- **Cleaning method** – existing Department of health cleaning policies were reviewed. This assisted in the development of cleaning procedures. Sustainability was a consideration and microfibre cloths and mop heads were purchased to reduce chemical use and ease physical effort.
- **Cleaning ergonomics** – A research of literature highlighted the musculoskeletal risk factors in the cleaning occupation and found that the main risks associated with cleaning include static muscle loads, repetitive movements and physical strain. To address this, the bucketless mop system was implemented and cleaners reported ease of use and a reduction in lower back pain and muscular strain at the end of the day.
Applicability to Other Settings

- Although this project was limited to private psychiatric hospitals, it demonstrates improvement in hospital cleanliness by the application of new technology, staff training and auditing.
- Sustainability is an important consideration given the amount of chemicals used in the hospital setting, the use of microfibre leads to less chemical use.
- Lost time in injuries is an important factor for any hospital and within such a short time cleaners reported less muscle strain.
Creating an Integrated Award Winning Total Safety Management System
Bentley Health Service, Safety and Quality Unit, Bentley, WA

Author
David Wallington  Occupational Safety and Health Consultant

Aim
The Total Safety Management System Project aim is to improve OSH performance through decreased lost time injuries, increased workplace productivity and improved departmental outcome performance.

Abstract
Bentley Health Service formulated and approved one strategic Occupational Safety and Health Plan referenced against all applicable ACHS Standards, OSH Acts, Codes of Practice, industry benchmarking standards and integration with risk management systems and principles.

The Total Safety Management Plan and System, was introduced to capture key performance indicators and improve on its Occupational Safety and Health performances.

An internal audit based on the Work Safe Plan of Bentley Health Service Occupational Safety and Health hazards, incidents, workers compensation costs and lost time injuries was conducted and performance indicators measured against industry benchmarks, which in turn were used to develop strategies to target identified gaps in OSH performance.

Once the Total Safety Management Systems had been developed, our next goal was to research benchmarking of Total Safety Management Systems in accordance with Public Sector Industry Benchmark Goals and Safety Standards. Consequently, in 2005, the WA Department of Health Internal Audit branch conducted an in-depth audit of our Total Safety Management System against the WorkSafe WA Plan and EQuIP standards.

The WorkSafe Plan is the preferred State Government Occupational Safety and Health assessment tool that measures occupational safety and health management systems on a continuum in relation to industry ‘best practice’. Bentley Health Service achieved excellent across-the-board results in establishing effective systems in the majority of WorkSafe Plan criteria, accumulating in the WorkSafe WA Silver Award in 2006.

The Bentley Health Service results clearly demonstrate a robust system for managing safety and health within the organisation. This has been achieved with a mind-set of continuous improvement at all levels of the organisation and an engagement from staff at all levels.

Application of EQuIP Principles

Customer focus
- Consumer Advisory Council consultation and representation on the Quality and Risk Management Committee.
- Consumer Advisory Council consultation and representation on Disability Services Committee.
- Consumers have access to the Bentley Health Service Consumer Advisory Council via feedback mechanisms including complaints/ compliments and feedback.
Effective leadership
- The findings from the WorkSafe Plan Audit in 2006 give strong evidence that Bentley Health Service’s commitment to improving safety leadership is robust and culturally ingrained.
- There is strong evidence of substantial continued commitment by both management and employees in achieving safety objectives.

Continuous improvement
- Safety Management Systems judged as implemented successfully and improved over time to a level of ‘best practice’.
- Planning at a micro level for individual systems is significant and strong evaluation systems are in place.
- Safety and Health Strategic plans promote the principles of EQuIP and continuous improvement.

Outcomes
- Excellent across-the-board results in establishing effective systems in the majority of WorkSafe Plan criteria, accumulating in the WorkSafe WA Silver Award in 2006.
- A robust system for managing safety and health within the organisation has been achieved with a mind-set of continuous improvement at all levels of the organisation and an engagement from staff at all levels.
- Bentley Health Service is recognised as an industry leader in the provision of safety services such as: Infection Control, Waste Management, Security, Dangerous Goods and Hazardous Substances, Radiation Safety, Manual Handling, Building Plant and Equipment, Injury Management, Emergency Response and Dealing with Aggression.

Striving for best practice
- Goal to achieve Occupational Safety and Health WorkSafe WA Gold Status in 2009 within a complex ever changing risk environment.
- This award status demonstrates continuing best practice achievement.

Innovation
- Formulating the strategic plan, gaining consensus on the plan, progressing the plan, sticking to the plan whilst accommodating changes incorporated within the South Metropolitan Area Health Services Operational Plans.
- Ongoing research to address challenges and support necessary changes.
- Integration of the strategic plan within the clinical streams.
- Setting standards for other health services to aspire to.

Applicability to Other Settings
- Adaptation of the Bentley Health Services Total Safety Management Systems has occurred across several other Western Australian health services.
- The Bentley Health Services Total Safety Management System model can be applied to other health service settings.
Effective Management of Clinical Equipment in a Rural Area Health Service
WA Country Health Service- South West (WACHS-SW)

Author
Pauline Crommelin, Clinical Equipment Coordinator

Aim
Involving the clinician in the purchase and ongoing management of clinical equipment ensures the right equipment is purchased for the right purpose at the right time.

Abstract
Clinical equipment represents a significant capital investment for any area health service. Equipment is difficult to come by and when services change and the equipment is no longer required, it is difficult for the staff to part with it. Fully utilising resources wether by moving it from one area to another or purchasing something fit for purpose requires considerable consultation with clinicians.

   Systems and strategies were developed to ensure rationalisation of resources within an area health service. The South West covers an area of 23,970 square Kilometres with the largest population outside the metropolitan area.

Application of EQuIP principles, evaluation process, effectiveness and sustainability
This project utilised the quality cycle at each step. All processes were evaluated and changes made. The plan, do, check, act cycle is fundamental to this process.

Customer focus
   o Equipment that is fit for purpose was evaluated.
   o The changing needs of the service are constantly evaluated
   o Clinicians are the customers, under this system

Effective leadership
   o Collaboration between all disciplines
   o Shared vision with an agreed goal

Outcomes
   o Strengthening of the clinical equipment management system
   o Utilisation of limited financial resources
   o Working relationships with outside providers of biomedical engineering
   o A sustainable Bariatric equipment replacement programme
   o Risk rated equipment replacement programme with clinical input
   o Standardised equipment purchased to meet standards appropriate to service delivery
   o Involvement in policy decisions between biomedical engineering, manufacturers and service delivery

Striving for best practice:
   o Bariatric equipment programme is following best practice principles.
   o Keeping abreast of current trends through the establishment of functional networks the various industry experts.
   o Standardisation of equipment to help minimise clinical risk due to unfamiliarity
Innovation
- Strategies developed are reducing costs of maintenance of clinical equipment
- Web based resources
- Newsletters to communicate to the staff

Applicability to other settings
These processes are currently being devolved to other regional districts within the WA Country Health Service. It could be applied to other health facilities
Engineering Department Quality Improvements, 2005-2007
Bendigo Health, Engineering Department, Bendigo, VIC

Author
Greg Ellis  Mechanical Engineer

The aim of this report is to convey the quality improvements made by the Bendigo Health Engineering Department in the last two years in order to successfully apply for an award from ACHS within the non clinical category.

Abstract
Emphasis has been given to the contribution of the departments Document Management Systems and specifically the Space Management System. It should be noted that one of the key Quality Improvement benefits of the Space Management System described in this report is that the System can be used by any of the Departments within the Health Care Group where the reference of a location is required.

Other Quality Improvements relate to energy and water conservation, control systems, reliable power supply and general operational improvements instigated by the Engineering Department.

Application of EQuIP Principles

Customer focus
• Installation of new high voltage transformers at the Bendigo Hospital to ensure a more reliable power supply and business continuity.
• Installation of uninterruptible power supply to theatre’s, critical care, renal dialysis and Information, Communications, Technology.
• Weekly meetings with aged care and psychiatric managers to ensure maintenance issues are addressed.
• Installation of electrical surge suppression at the Alexander Bayne Centre, Carshalton House, Golden Oaks Nursing Home, Simpkin House, Vahland House, Stella Anderson Nursing Home, Critical Care and Special Care Baby Unit to reduce the risk a fire caused by surges in power supply.
• Installation of a new computerised maintenance management system to better ensure maintenance is completed on time.
• Project and maintenance data is now added to the Engineering Departments intranet web page.
• Installation of Thermostatic Mixing Valves to reduce the risk of a patient, member of the public or staff member from being scalded.

Effective leadership
• May 2005 Institute of Hospital Engineers professional development day hosted by Bendigo Health, demonstrating the control room housing the building management system.
• April 2007 Institute of Institute Hospital Engineers professional development day hosted by Bendigo Health demonstrating the water saving projects undertaken.
• Two presentations to Bendigo Business and Industry Environment & Sustainability network on water and energy saving initiatives.
• Presentation to Institute Hospital Engineers on water saving initiatives.
• Achievements in Energy reduction published by the Federal Governments Greenhouse Challenge Plus program of which Bendigo Health is a member.
• Articles within the Bendigo Advertiser, Bendigo Weekly, Institute of Hospital Engineers National Magazine and air time on Win Television displaying the Departments Energy and Water saving achievements.

**Continuous improvement**

• Survey of all trade staff to obtain there views on the operation of the Engineering Department. Resulted in the apprentice mentoring program where apprentices spend two days with each engineer.
• Apprentice swap program initiated giving plumbing apprentices experience within the private sector.
• Allowing multi level user access to all space management drawings via the intranet. Follow up the development of space management drawings for all buildings throughout the group.

**Outcomes**

• Annual $30,000 saving in operating costs since the re-design of existing air conditioning control systems.
• Saved 3 million carbon dioxide balloons during a “switch off” campaign in March 2007.
• Reduced water consumption at the Bendigo Hospital by 100,000 litres a day.
• Introduced a contractor induction and management program to reduce the risk of infections resulting from building works.
• Development of fire and smoke wall drawings for all buildings across the group and issued to contractors as a follow up to space management drawings.

**Striving for best practice**

• Bendigo Health Engineering Department recognised by the Department of Human Services and other Victorian Health Care agencies as a model department. Demonstrated by Chief Engineer David Walker being voted by his pears as the 2005 Institute of Hospital Engineers as Engineer of the year.
• Over 3000 documents filed for use throughout the group. Including building plans, permits, fire audits, catalogues, electrical safety certificates, and other compliance documentation.
• Plan developed to fit room numbers to all rooms throughout the group. Allows for easier completion and documentation of maintenance tasks.

**Innovation**

• First Victorian health care organization to successfully apply for a grant from the Stormwater and Urban Water Conservation Fund.
• Bendigo Health Linen Service will become the first Victorian Laundry to operate using Class A recycled water via a successful application for funding from the Smart Water Fund.
• First Victorian hospital to install a dedicated control room for monitoring plant throughout the hospital.

**Applicability to Other Settings**

• Department of Human Services (DHS) to use the renal dialysis water recycling system at Bendigo Health as a model for employing this technology throughout all public hospitals within Victoria. Demonstrated by the Operation, Maintenance and Controls manual for the system displayed on the DHS website.
• Capital management branch of DHS visited the Engineering Department in December 2006 as a model department and show cased the Departments achievements in their quarterly report.
Evaluation of a Multidisciplinary Human Factors Course in a Rural Setting of Australia
Hunter New England Health Service (HNEAHS) with Involvement of New England Area Training Services (NEATS) and Northern University Department of Rural Health (UDRH), Hunter New England Area Rural Training Unit and Area Nurse Education, Emergency Critical Care (Northern Sector), Tamworth, NSW

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Aim
This project aims to assess the impact of a multi-disciplinary human factors course integrated with existing resuscitation training courses for GP registrars and nurses at rural hospitals in the Northern Sector of Hunter New England Area Health Service in March 2007.

Abstract
Human factors account for 70% of medical error. This pilot assesses the impact of a multi-disciplinary human factors training course integrated with resuscitation training for GP registrars and nurses in rural hospitals in HNEAHS. Two workshops (6 groups) involving 16 GP registrars and 17 nurses were conducted in March 2007. Changes in safety attitudes and protective behaviours were measured pre and post human factors training. Statistically significant changes in protective safety attitudes and behaviours were observed post training. All respondents would attend further emergency skills training and 94% would attend further multi-disciplinary human factors training. Multi-disciplinary human factors training is feasible in a rural setting and can be incorporated with resuscitation skills training workshops. A three month evaluation is planned. This project shows experiential educational scenarios can influence safety attitudes and behaviours to reduce the common sources of error in rural areas: communication; role delineation and definition; planning to reduce error; and work culture.

Application of EQuIP Principles

Customer focus
- This human factors training project seeks to reduce common sources of error in rural settings.
- The project involves scenarios to improve communication between health professionals and patients in a rural setting.

Effective leadership
A multi-disciplinary steering committee comprising doctors, nurses and patient safety staff agreed on the need for a local rural human factors course and developed a curriculum with input from the Royal Australian College of General Practitioners and Australian College of Remote and Rural Medicine.
Continuous improvement

- This course content is based on literature review, stakeholder consultation and review of 21 root cause analyses from 2004 – 2006 which investigated serious errors in the rural areas of Hunter New England Area Health Service (HNEAHS).
- Common sources of error included: communication; role delineation and definition; planning to reduce error; and work culture (creating a safe work environment).

Outcomes

This form of training is highly valued and results in changes in attitudes and behaviours.

- All respondents (100%) would attend further emergency skills training and 94% would attend further multi-disciplinary human factors training. 87.5% of participants agreed that the SHELI model and the SBAR frameworks for communication were useful to their training. All (100%) found assertiveness and use of critical language useful, while 94% valued the team management activities.
- Two statistically significant positive changes in attitudes to safety were found. After training more participants agreed that: junior team members should question decisions made by senior members (Fisher's exact, p = 0.026); and team members should share responsibilities for prioritising activities in high workload situations, (Chi = 7.62, df = 2, p = 0.02).
- After training statistically significant improvements occurred in the observability and frequency for the following safety protective behaviours in all groups: orientation, listening, decision making, action, attention, global communication and coordination, situational awareness, workload, and risk management. On a scale of 1 (rare or absent) to 4 (consistent or outstanding) mean behaviour scores increased by 1.0 from 2.18 to 3.18 (CI 95% 0.88 - 1.1).

Innovation

Crew resource management courses have been used in the airline industry, surgery, emergency departments and anesthetics to reduce error. These courses focus on human factors: the science of how humans interact with each other and devices at work. To date there has been limited application of this form of training in rural areas or general practice.

Applicability to Other Settings

- This project supports Commonwealth Rural Health Support Education and Training objectives and priority areas to support, educate and train the rural and remote health multi-disciplinary workforce utilising an innovative method from aviation and applying it to rural health.
- The project also supports the “New Direction for NSW State Health Plan Towards 2010” in terms of building a sustainable health workforce; and improving safety.

Rural Health Support Education Training Program Project 123 provided funding for this project.
Evolution of a Management Development Initiative Within Hunter New England Health
Hunter New England Health Organisational Capability and Learning,
Workforce Development Directorate, Waratah, NSW

Author(s)
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Data support from Kay O'Rourke and Kathy Ingham

Aim
Design and implement a development program for managers that meets the evolving needs of HNE Health managers and the organisation.

Abstract
Following organisational review, the Hunter New England Health (HNE Health) Area Executive Team commissioned the development of a management development program to solve specific challenges facing HNE Health front line managers. These challenges, as highlighted by a number of consumer and staff feedback and review mechanisms, informed the research and design of the intervention.

Continual evaluation and learning by the designers/facilitators of this program ensured the program was adapted in line with evolving organisational needs. The 3 evolutionary milestones are:

   - Nine face to face workshops which are short and targeted modules, scheduled close to workplace.
   - Learning cohorts facilitated by local content matter experts.

   - Three blended learning modules (50% e-learning, 50% face-2-face workshops).
   - Learning cohorts facilitated by professional facilitator with co-facilitators (content matter experts).

   - Critical review of material (ensure ongoing alignment with organisational strategy).
   - Improve enrolment and recognition process (move from “mandatory attendance” to “Mandatory Capability”).

Major outcomes achieved:
- Achieved initiatives on time and on budget.
- Significant improvements in management confidence to exercise management responsibilities (Full results in Appendices I and J).
- Improved learning access and relevance for rural managers.
- Improved recognition of experienced managers attending the mandated program.
- Agreed and embedded standardised management practices across the HNEAH.
- Formally linked learning with manager’s ongoing performance development and encouraged skill transfer to the workplace.
- Reduced learning time from 41 hours (Management Fundamentals) to 29 hours average (Management Essentials), with no loss to learning experience or outcomes (Saving a notional $48 600 in salaries in the first year of ‘Management Essentials').
Application of EQuIP Principles

Customer focus
- Consultation with primary and secondary stakeholders throughout program implementation (focus groups, surveys, learning service agreements).
- Learning delivery platform evolved to reduce time away from office.
- Ongoing support (coaching and guidance) provided to participants by facilitators.
- Pending improvements recognise pre-existing knowledge of participants, improving their learning experience with Management Essentials.

Effective leadership
- Visible Senior Executive sponsorship of program.
- Content matter experts asked to provide visible leadership to their front line managers by facilitating the sessions.
- Principles and approaches to effective leadership permeate the course material.
- HNEAH OCL have shared their material with all NSW Health Services.
- HNEAH OCL have provided leadership to the development and project management of the NSW Health Medical Clinician Manager training initiative (applying several ‘Management Essentials’ design methodologies and materials).

Continuous improvement
- Design methodology included design input, design verification and design validation processes, using adult learning, curriculum design and evaluation techniques that assure the application of validation and improvement methodology.
- Three evolutionary milestones in two years indicate that this program continually evolves in line with emerging organisational and learner needs.

Outcomes
- Continued evaluation of quantitative and qualitative data indicated opportunities for improvement at every stage.
- Most significant outcomes (reflected in appendices): improved management confidence to perform their role, improved delivery efficiency (from 41 hours average to 29 hours average), improved engagement of the participant’s manager with the participant’s learning, and linkage of learning with performance review.

Striving for best practice
- OCL have benchmarked this program and management development practices with other NSW Area Health Services, ACT Health and the University of Newcastle.
- We have been recognised as leaders in our field by NSW Health and ACT Health, and have been invited to share our experience at conferences. E.g. “Nursing Leadership Conference Sydney 2006: “Leadership and Change”.
- OCL are presently continuing to research international evidence of best practice and seek to learn more from the NHS experience in Leadership and Management Development Practice.

Innovation
- Harnessing content matter experts to design and deliver the modules (rather than relying on our usual professional facilitators).
- Trialing an e-learning delivery platform to reduce the time to complete the learning.
- Testing a hypothesis for organisational learning that, if proven, will be used to influence managers to be more involved in their employees’ learning attempts.
Applicability to Other Settings

- Design methodology and material has been applied to the NSW Health “Medical Clinician Manager” training program.
- Management Fundamentals material was provided to NSW Health for access by area health services within NSW.
Food Services Restructure
Princess Alexandra Hospital Health Service District, Corporate Services, Woolloongabba, QLD

Author(s)
Harry Manolopoulos   Director, Nutrition and Operational Support Services
Steve Day Manager  Food Services
Tracey Cocciolone   A/Corporate Improvement Manager

Aim
The Food Services Restructure Project aimed to address issues raised by patients and staff regarding the provision of appropriate food services to all patients (and particularly those in the long stay ward areas) and the ability of the systems used in the central kitchen to cope with changes in patient profile and activity.

The restructure was completed over a four month period and has been successful in improving services to patients and staff employed in the food services department.

Abstract
The key activities surrounding the Food Services Restructure focussed on the implementation of a hostess trolley system, initially trialled in the Mental Health Unit to fine tune processes and rolled out to the GARU areas and then the Spinal Injuries Unit.

Staff were trained, work procedures written and consultation occurred with the clinical and operational staff to finalise processes. Production, procurement and business support areas within the Department of Nutrition and Operational Support Services were included in the trial.

Outlying areas were previously provided with a bistro type service based on a seven day menu cycle. As part of the implementation the following changes were made:

- The system was changed from a bulk service plated in peripheral kitchens in each of the areas to a Hostess style trolley system.
- Meals are plated at the bedside or beside the patient.
- Menu cycle was extended from 7 days to 14 days.
- Mid meals food items were increased to encourage patients on eat more. (Nutrition Department Malnutrition Screening indicates that these patients are in the high risk group for malnutrition).
- Menus and services were finalised in conjunction with consumers, carers, clinicians, allied health staff and operational staff.
- The food services department internal structure was changed so that the patient was placed at the top of the organisational chart. (Before and after structures are included in Appendix 9).
- The restructure of the central kitchen occurred in December 2006.
- Menu cycles, nutritional analyses and mid meals provisions were finalised in September 2006.
- Menus, ingredients and new food items were sourced and procurement requirements finalised in November 2006.
- The change to the hostess trolley system began in October 2006 and was finalised in December 2006 with the roll out in SIU.
- All food service staff in outlying wards were reassigned to The main hospital building by December 2006.
- Baseline measurements of services were conducted from August 2006.
- A Patient satisfaction survey was conducted in September 2006 and then in March 2007.
Application of EQuIP Principles

**Consumer focus**
The following mechanisms were used:
- Patient Satisfaction Surveys.
- Focus groups Rehab Areas and Mental Health.
- Nutritional Care Committee.
- Food Presentation.
- Food Services Management Group and Menu Review Committee.
- Union and Industry Consultation.

**Effective leadership**
The Project was led by the following:
- Nutrition and Operational Support Services Senior Management.
- The Food Services Management Group and the Menu Review Committee.
- Was sponsored and supported by the Executive Management Group.

**Continuous improvement**
- Key performance Indicators used to measure the service.
- Standards are measures are reviewed and improved.
- Patients asked to comment on the service.
- Allied health, clinical and nursing areas are also involved in planning the services.

**Outcomes**
- Productivity in areas of food production (sandwiches and salads), meal delivery, meal collection, mid meal provision and ware washing improved.
- New services to outlying areas were implanted and included change of menu cycles from 7 day to 14 day, increase in provision of mid meals items and services provided at the bedside.
- Food presentation improved so patient meals look more appetising.
- Overall satisfaction increased and the patient satisfaction survey will be changed to obtain better qualitative information from the patient.
- Staffing structures changed to more intimate work groups with the patient at the top of the organisational chart.

**Striving for best practice**
- The Service has been benchmarked with other institutions in Queensland South Australia and New South Wales. These included public hospitals, a convention centre and a private service provider.
- The PAH ranked very favourably in the areas of meal tray plating, Meal delivery and was ranked as the hospital with the highest meals produced per FTE.
- The PAH used lower staffing numbers on plating lines than another hospital of similar size.

**Applicability to Other Settings**
- The menu cycle, meal delivery and mid meal service concept can be applied to other long term care facilities. The hostess trolley system has been successfully used by other hospitals.
- The food presentation, scheduled mid meal items, and links to malnutrition screening can be utilised by other long term care facilities, however significant measurement needs to occur to gauge whether food presentation affects malnourishment.
How Research can Improve Quality of Care for Women in Adelaide and Australia
Noarlunga Health Services, Noarlunga, SA

Author(s)
Wendy Abigail  CN Family Advisory Unit, Noarlunga Hospital, Primary Researcher
Jen Kay  Quality Assurance Manager, Noarlunga Hospital

Aim
The aim of this report is to assess whether research conducted into trends in five characteristics of women who underwent a termination of pregnancy has had an impact on quality care improvement.

Abstract
The research project investigated characteristics of women who underwent a termination of pregnancy from 1996 to 2006 in two service providers in Adelaide to assess any changes in trends which may impact on service delivery for this group of health care consumers. Additionally, the results may improve quality of care by service providers and other health professionals such as women’s health workers, policy and strategic planners for women’s health issues, health professionals interested in women’s health and government bodies.

Method
A time-series study, from 1996 to 2006, using 6888 cases from the two service providers, examined five characteristics associated with women attending for a termination of pregnancy. Data from was examined using simple linear regression analyses and one-way ANOVA.

Results
There was a significant increase in women aged 30-50 years (ANOVA F1,9 = 5.901, p=0.041) having a pregnancy terminated at the southern service, with 67% of women using contraception at the time of conception at both services. An increasing percentage of women chose not to use any contraception post-operatively at both services (southern ANOVA F1,9 = 14.409, p=0.006, northern ANOVA F1,9 = 14.331, p=0.005), although 90-93% of women left the services with contraception. Additionally, there was a significant decline in women using natural family planning methods (southern ANOVA F1,9 = 13.654, p=0.006). Referral patterns changed significantly over the ten years, with less women being referred by a general practitioner (southern ANOVA F1,9 = 46.492, p=0.000, northern southern ANOVA F1,9 = 8.672, p=0.019) and family planning clinics (southern ANOVA F1,9 = 13.011, p=0.007, northern ANOVA F1,9 = 9.601, p=0.015).

Conclusions and implications
Termination of pregnancy patterns have changed over the past ten years. National media coverage of the results occurred in all the major newspapers around Australia following presentation at an international health conference. Requests for detailed information from Government departments in South Australia, the ACT and Western Australia have followed. A number of articles have been submitted to peer-review journals. This study shows that implications for policy, strategic plans and health promotion activities need to reflect these changes. Invitations for active involvement on government committees have seen involvement in the development of a Sexual Health Strategy for South Australia, and the committee for the Development of Best Practice for Termination of Pregnancy Services in South Australia. Presentations have been given at a local level for women’s health groups. Further research has commenced examining the results in greater detail.
Application to EQuIP Principles

**Customer focus**
- The primary focus of this research is to better understand the customer/patient.
- Knowledge is then able to be used to provide an ongoing understanding of the needs and expectations of present and potential customer/patients.
- Care planning and policy development is informed by a customer focus.
- Consumers of this information include women’s health workers, policy and strategic planners and other health professionals.

**Effective leadership**
- Data has been presented, locally, nationally and internationally
- Reporting relationships exist within the service and regionally.
- There has been support for researcher from the organisation.
- Requests for additional information/support have been received from government departments across Australia.

**Continuous improvement**
This research project has helped staff look for ways to improve service provision eg:
- monitoring outcomes through the recording and reporting of key performance indicators eg. waiting times, infection control data
- benchmarking with other services has been initiated
- continual monitoring of data ensures prompt identification of potential issues.

**Outcomes**
- Process and outcome measurement undertaken throughout project.
- Ten years of data collection underpins the research.
- Data is compared with another service.
- Development of sexual health promotion activities is evidence based.
- Research is informing health policy at a state level.

**Striving for best practice**
- An examination of the evidence identified gaps in knowledge/best practice guidelines so internal data sources were used to create the evidence.
- Our commitment to best practice is best demonstrated by a willingness to share research and assist others to apply the knowledge within their own work.
- State wide committees are using this research to inform policy development.

**Innovation**
There is limited national and international research in this area.

**Applicability to Other Settings**
This project demonstrates the link between research and policy development and could be adapted in any area where there is limited evidence available.

**Acknowledgments**
This research could not have taken place without the outstanding support of Dr. Charmaine Power Associate Professor, Flinders University Adelaide, or support from Dr Ingrid Belan, Flinders University, Adelaide, Graeme Tucker statistician Epidemiology Branch South Australia and Kylie Lange Biostatistician Flinders University.
Human Resources Management  
Kareena Private Hospital, Caringbah, NSW

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Sue Ransom  Performance Improvement Coordinator

Aim
Through improvement of patient and employee satisfaction Kareena will be a Healthcare facility and employer of choice.

Abstract
Following development of a new strategic plan in 2006 Human Resource practices at Kareena Private were targeted in an attempt to significantly improve employee and patient satisfaction. The aim of this initiative was to position Kareena private as an employer and health care facility of choice. In order to address and continue working towards achievement of magnet status four working parties were established.

Within a six to seven month time frame old identified issues had either been resolved or new initiatives had been implemented.

Application of the EQuIP Principles

Customer focus
• Implementation of Smiles programme.
• Employee benefits programme.
• Implementation of Mother and baby massage.
• Heart week.
• Seniors week.
• Diabetes week.
• Participation in Australia’s biggest morning tea, SIDS and kids week.
• Implementation of General Practitioner education.
• Implementation of monthly Ambulance Education sessions.

Effective leadership
• Succession planning.
• Implementation of the Ramsay employee club (Pegasus).
• Implementation of the Ramsey employee assistance program.
• Leadership development programs.
• Corporate health fund discounts.
• Financial and tax education.
• Onsite massage and beauty service.
• Emergency department discounts.
• Pathology and xray service bulk billed for staff.
• A change to staff morning tea.
• Implementation of a balance and well being program.
• A 10,000 step program.
• Formal recognition and acknowledgement of continuous years of service.
Continuous improvement
- Professional development sessions and log books.
- Education planning and implementation strategies.
- Access for all staff to the national online library service.
- Implementation of patient feedback cards.
- Implementation of volunteers program.

Outcomes
Implementation of thank you letters to staff for “going the extra mile”

Striving for best practice
- Procedures are reflective and evidenced based.
- Knowledge and skills are assessed against competency guidelines.
- Establishment of Clinical Nurse Specialist focus groups.
- Implementation of a monthly award for outstanding customer service.

Innovation
- Implementation of quarterly hospital wide thank you breakfast lunch and dinner for all staff.
- Implementation of a managers toolkit that allows managers to reward to direct reporting staff in a timely manner for commitment and service.

Applicability to Other Settings
It was deemed by the authors is that the majority of the above would be easily implemented by other health facilities. A number of the initiatives developed within the hospital have been previously implemented in other organisations and have been adapted for Kareena Private Hospital.
Implementation of a New Policy System in the South Metropolitan Area Health Service
Royal Perth, Fremantle Hospital, Bentley, Armadale, Peel & Rockingham, SMAHS Policy Unit, Perth, WA

Author
Carolyn Saunders, Acting Manager SMAHS Policy Unit

Aim
To ensure that best practice in policy development is implemented throughout the South Metropolitan Area Health Service.

Abstract
The SMAHS Policy Unit introduced a new Policy System throughout the SMAHS in August 2006. It assisted the Fremantle and Rockingham Peel Groups to meet the EQuIP 3rd Edition criteria 2.1.2, 2.1.4, 2.1.5 in their Organisational Wide Surveys in February 2007 by drafting their corporate policies, the SMAHS Governance Policies, and SMAHS Authorities, Delegations and Directions Schedule.

There has been a significant improvement in the quality of policies throughout the SMAHS with a standardised policy document, consistent language and links to relevant legislation and Government policies. The drafting and review process has been streamlined and document control has been introduced. Feedback from throughout the SMAHS has been positive and our work on behalf of the Groups / sites / services is welcomed.

Application of EQuIP Principles
Although there is no formal evaluation process for policy development, each policy is evaluated to ensure that it conforms to Policy Unit requirements. Constructive feedback is received from SMAHS staff about policies sent to them for review. Positive feedback has been received from each SMAHS Group/Site about the services that the Policy Unit provides. The Policy System and service we provide are considered to be effective and sustainable.

Consumer focus
All SMAHS Staff are SMAHS Policy Unit Customers
To facilitate staff access to SMAHS and Group/Site Corporate Policies the following actions were implemented:
- Creation of a dedicated “Policies” folder on SMAHS Intranet.
- Creation of Sub-folders for Area, Group and Site specific policies.
  - Each sub-folder has its own sub-folders based on the EQuIP 4 Clinical, Support and Corporate Functions and policies related to the criteria are located in these appropriately titled folders.
- Providing the Rockingham Peel Group staff with access to their electronic manuals on the SMAHS Intranet.
- Enhancing RPH staff access to the SMAHS Intranet by providing a direct link to it from the “SMAHS Governance Policies Manual” button on the RPH Intranet.

Effective leadership
- Streamlining the process for notification of issues, initiating follow-up actions and “closing the loop” for the Fremantle Hospital Executive Group to ensure there is compliance with legislation and Government policies.
• Streamlining the process for policy distribution and implementation at RPH and Rockingham Peel Group.
• Notifying Area and Group Executive when legislation or Government Policy changes require amendment or creation of SMAHS or Group/Site policies.
• Other agencies and organisations regularly contact the SMAHS Policy Unit for advice about policy development.

**Continuous improvement**
• Converting, reviewing and drafting Armadale Health Service corporate policies.
• Drafting corporate policies for Bentley Health Service.
• Continuing to draft all SMAHS Governance and Group/Site-based corporate policies.
• Re-categorising and re-coding all Group/Site corporate policies from the EQuIP 3 functions into EQuIP 4 functions and criteria.
  o The RPH Policies and Procedures Manual has already been re-categorised and re-coded and the electronic manual on “Servio Online” enhanced.
• Revising the SMAHS Authorities, Delegations and Directions Schedule.
• Education sessions scheduled for RPH and Armadale Health Service and they will also be provided to Bentley Health Service when their manual is completed.
• Upgrading SMAHS and Group/Site Legislative Compliance Registers.

**Outcomes**
• By the time the projects were completed the SMAHS Policy Unit had drafted and submitted for endorsement:
  o 89 SMAHS Governance Policies
  o 66 Fremantle Group Corporate Policies
  o 58 Rockingham Peel Group Corporate Policies
  o 6 South Metropolitan Mental Health Service Policies
  o SMAHS Authorities, Delegations and Directions Schedule.
• Legislative Compliance Registers for the three policies manuals have been developed.
• Document control and metadata introduced.
• The Fremantle Group received a MA rating for the EQuIP 3 criteria 2.1.2, 2.1.4, 2.1.5 and the Rockingham Peel Group received an EA rating for these criteria.

**Striving for best practice**
• Participating in a Project Control Group responsible for tendering for a commercial legislative compliance program.
• Developed comprehensive benchmarking tool to look at policies and legislative compliance.
• Establishing a Health Policy Network in Perth.
• Continuing our close liaison with the NMAHS.
• Developing a formal evaluation process for policy development and implementation at each Group/Site in the SMAHS.

**Innovation**
• Work is about to commence on upgrading all our policy data bases so that it is easier to link them to legislative changes, Department of Health Operational Directives, Australian Standards and ACHS standards and criteria.
• Notification service to Executive, Management and key personnel about changes to WA/Commonwealth legislation, Australian Standards, Premier’s Circulars and Department of Health Operational Directives.

**Applicability to Other Settings**
This policy system is applicable to all health services.
Introducing a Safety Model in an Acute Hospital
Melbourne Health, Royal Melbourne Hospital, City & Royal Park Campus, Parkville, NSW

Author(s)
Elisa Ilarda  Project Co-ordinator
Brian Jackson  Senior Nurse Advisor

Abstract
Melbourne Health prioritised the implementation of an approach to minimise clinical aggression in the workplace in 2005 and Project Co-ordinator, Elisa Ilarda was appointed to implement a model across two sites of the Royal Melbourne Hospital. Brian Jackson, NWMH Senior Nurse Advisor provided leadership and Executive representation to this project.

A number of activities were developed this time to address the diverse facets of this issue in acute health. Some of these include the development of: policy, code grey guidelines, training curriculum, staff Manual and intranet resources.

Up to date, evaluation of the content of the training indicates a significant increase in confidence for all staff completing the training, particularly, in staff’s ability to feel safer when confronted with an aggressive incident. Up to date, over 900 staff members have completed the training. External organisation have also contracted Melbourne Health to provide their staff the same model within their acute hospital settings with ongoing interest for future.

Of recent, Code Grey calls have also significantly decreased within the organisation indicating another positive outcome of the project.

This training mode in acute health has been promoted to both national and international conferences.

Application of EQuIP Principles

Customer focus
- The project acknowledges that consumers, staff and carers all have a right to feel safe in a hospital environment.
- A consumer representative participated in the development of all activities related to the project.
- The patient advocate was also involved in all working groups of the project.

Effective leadership
- An Executive Committee was formed for this Project.
- A Steering Committee comprising of 26 senior representatives from the organisation took part in fortnightly meetings.
- Executives officially launched the project in May 2006 at both sites of the Royal Melbourne Hospital (RMH).
- Management members supported the project by completing the first sessions of the training being offered across the organisation.

Continuous improvement
- The Steering Committee meets at quarterly intervals to review all projects’ activities.
- Drills / simulations in wards will begin once a significant number of staff have been trained.
• Working groups have been developed to address aggression in areas of high prevalence such as the emergency department and aged-care wards.
• A mechanical restraint study is also underway to address the use and frequency of mechanical restraints used by staff at the RMH.

Outcomes
• Occupational Health and Safety Data demonstrates a significant decrease in the severity (days lost) of Workcover claims from 2005-2006.
• Confidence Questionnaires indicate a significant increase in confidence for staff completing the training. A large effect size was found on all items assessed.
• Evaluations of training indicate a high degree of satisfaction for all modules presented.
• The MAVAS assesses staff’s perceptions around how aggression is managed on their wards. Staff reported that relationships between staff and patients could be improved and the use of traditional techniques (e.g. restraint) should be used less frequently. The same tool will form the baseline for a longitudinal evaluation.

Striving for best practice
Melbourne Health will continue to implement interventions to enhance the safety of staff, consumers and carers within their acute hospital sites and strive for best practice in order to provide a safe and therapeutic environment for all.

Innovation
• One of the first approaches to be used in an acute health setting.
• Other hospitals following the Melbourne Health Model.

Application to Other Settings
• Other organisations have also indicated interest to adapt this model within their work setting with one negotiation recently been endorsed.
• Transferable across all hospital systems.
Kids Health Information for Parents - A Process for Collaborative Involvement and Ongoing Evaluation by Consumers and Clinicians
Royal Children’s Hospital - Melbourne, Quality & Safety, Parkville, VIC

Author
Susan Jury Kids Health Information Coordinator

Aim
To ensure healthcare information written for parents is both evidence-based and written appropriately, through a robust and collaborative development and review process, including consumer involvement and feedback.

Abstract
The RCH ‘Kids Health Info’ website (www.rch.org.au/kidsinfo) is a valuable resource for parents and healthcare providers. It contains more than 200 parent information factsheets and has more than half a million visitors a year from across Australia and globally.

An established process ensures new and updated factsheets are evidence-based, reviewed by all relevant clinical groups and written according to present commonly accepted practice.

As well as being authoritative and trustworthy, to ensure new and existing factsheets were accessible and relevant to consumers, consumer involvement in the development and review process was also necessary. Consumer input is part of the development process and a simple and ongoing online user survey was commenced in September 2006. Following up on feedback is key to the survey’s success.

The result has been an effective and sustainable way to ensure ongoing evaluation and improvement of authoritative, appropriate and accessible parent information online through collaboration between clinical experts and consumers.

Application of EQuIP Principles

Customer focus
- Consumer involvement in the development and review process.
- Collection of consumer input before commencing the development of factsheets.
- Factsheets also written by consumers, support groups and volunteers.
- Factsheets developed in response to requests from parents and other consumers (such as child health nurses, teachers, community pediatricians).

Effective leadership
- Providing health information online is increasingly important as internet access continues to grow and consumers have access to subjective, often inaccurate information. RCH strives to provide information that is evidence-based and medically accurate.
- Robust development and review process and ongoing consumer involvement.
- Multidisciplinary collaboration between relevant clinical groups, specialists as well as consumers.
- Established robust processes driven by a principal specialist clinical author (for example, doctor, nurse or allied health) and supported by the Kids Health Info Coordinator ensures ownership of the website by all staff.
Continuous improvement

- Factsheets are reviewed and updated every 2 years, or more often if required.
- Provision of a volunteer online survey accessible at the end of each factsheet.
- Consumer feedback is reviewed quarterly and suggestions are addressed. Consumers leaving contact details are invited to assist with the review of factsheets.
- Lists of updated and reviewed factsheets are regularly distributed, with recipients invited to provide feedback, creating a cycle of responsiveness.
- Consumer feedback, constructive and positive, is followed up with authors.

Outcomes

- High consumer satisfaction - 87% of surveyed respondents found the factsheets “very useful” or “useful”.
- Significant feedback received on existing factsheets via the online survey resulting in 62 factsheets being reviewed or updated.
- Consumer input is built into the factsheet development and review process.
- Factsheets have also been written by parents, adolescent consumers and consumer support groups.
- More than 1500 visitors daily - from within RCH, parents, patients, family doctors, community nurses and abroad.
- 200 up to date and relevant factsheets on the website.

Striving for best practice

- The established process ensures factsheets are relevant, appropriate, evidence-based, reviewed by all relevant clinical groups and written according to current commonly accepted best practice.
- Consumer involvement and input in the development and review.
- Ongoing evaluation and improvement of factsheets by users.

Innovation

The ongoing consumer survey provides an effective and sustainable way to ensure ongoing evaluation and continuous improvement of authoritative, appropriate and accessible parent information online through collaboration between consumers and clinical experts. We believe this process is unique in this setting.

Applicability to Other Settings

This model of collaborative development and consumer input would be equally applicable to the provision of other information to consumers of healthcare or any service industry.
Learn and grow - Workplace English Language and Literacy Program.
Sydney West Area Health Service -Corporate Services WENTWORTHVILLE, NSW

Author
Susan Shaw  Manager Corporate Systems Review & Redesign
Narelle Darby  Vocational Education Review, Development and Grants Co-Coordinator (VERDGC)

Aim
To provide opportunity for frontline staff to achieve a nationally recognised qualification at neutral cost to the Area Health Service

Abstract
In response to the theme contained in the SWAHS Corporate Plan 2003 – 2007 “Supporting our skilled and valued workforce” Corporate Services undertook to provide training to the staffing groups with the least opportunity of gaining qualifications in their vocational field. Upon investigation it was identified that Food and General Services (previously known as Environmental Services) staff had the least opportunity due to language and literacy issues. Many in this group were from culturally and linguistically diverse backgrounds.

After extensive investigation a Workplace English Language and Literacy (WELL) program was proposed, submissions prepared and submitted, and a Registered Training Organisation engaged.

After successfully obtaining WELL funding of $292,924.50 from the Department of Science and Training (DEST) together with an $88,765 commitment by the Area Health Service, 223 Food and General Services staff worked towards a Certificate II in Health Support. One hundred and ninety staff (85.2%) graduated from the program with this qualification.

Application of EQuIP Principles

Customer focus
- The customers identified for this project were the patients, staff and visitors who would receive the services of the staff, and the frontline staff that would receive the training.
- The competencies for the qualifications that the staff worked towards were chosen to assist the staff in maintaining a customer focus, and ensure that the services provided by the staff were of the highest standard.
- Staff were consulted in the decision making process to ensure that their learning needs were met with the competencies chosen.
- Staff literacy and language issues were taken into consideration when choosing the type of training program that would be undertaken, hence the WELL program.

Effective leadership
- The Area Health Service committed $88,765 as an in kind contribution and accepted the risk that if the program was not successfully implemented that the funding would need to be repaid to DEST.
- The Corporate Services Business Plans of 2004 / 2005 and 2005 / 2006 were aligned to the Area Health Services Corporate Plan. Initiative 3.5 of the Corporate Services Business Plan’s “Improve the ability of staff in Environmental / Food Services at Blacktown, Mt Druitt and Auburn Hospitals to interpret workplace documentation and achieve Australian Qualification Framework (AQF) qualifications” ensured accountability for the progress, monitoring and reporting of this initiative.
The Manager of Corporate Systems Review and Redesign was a member of the steering committee to demonstrate the Corporate Executive’s leadership and commitment to the success of the program.

Staff were given the opportunity to work towards the qualifications within work time.

This initiative was important in achieving Corporate Services vision of “providing indispensable service and value” to the organisation and our staff.

Continuous improvement

Although it is not essential for the staff to have a qualification to carry out their duties, Corporate Services recognised the need to improve the skill base of the staff and the services that are delivered to the patients / consumers.

The training materials used in the program were quality assured by Hunter TAFE to ensure they met VETAB standards.

Due to the success of the program, a submission was made for a second grant for which we were successful. This program is currently in progress at Nepean Hospital. ($227,000 to train a further 158 staff).

Retention rates are being measured.

Outcomes

190 staff gained a Certificate II in Health Support (85.2% of participants)

A further 27 staff completed at least one competency from the program.

The staff gained a sense of achievement through the program as demonstrated by the following quote from a participant at the graduation ceremony “... Had it not been for SWAHS’s commitment, some staff would never have had the opportunity to feel the sense of achievement, and experience the recognition, that is gained from undertaking a TAFE course” – Cheryl Menzies. Zeljina Dimitric, General Services Blacktown Hospital thanked SWAHS and TAFE teachers for the opportunity to complete the Certificate II Health Support as it will help her in her career.

All staff that participated in the program have been trained in, and assessed as competent, in the skills required to carry out their duties, ensuring that quality and safe services are provided to the patients / consumers and staff.

The participants were surveyed a year after completing the program. 97% agree that the program has better equipped them to carry out their duties. 32% have undertaken some other form of continuing education since completing the program. Two participants have gone on to achieve a Certificate IV in Frontline Management.

Due to the success of this WELL program, we have been successful in gaining a second WELL grant of $227,000 to role the program out to Nepean Hospital Food and General Services staff (158 staff).

Striving for best practice

The significant outcomes (as listed under Outcomes section) of the program demonstrate that Sydney West is achieving Best Practice.

Due to the success of our large WELL program, a number of private enterprises have sought advice regarding the implementation and management of WELL programs.

As the staff participating in this initiative worked towards a nationally recognised qualification, they were formally trained and assessed against set criteria and were deemed competent in the skills required to perform their work. This ensures improved outcomes for our staff, the organisation and our patients / consumers.

Evaluation Process

The program was evaluated using measurable outcomes such as the number of participants attaining a Certificate II in Health Support and the number of participants completing at least one competency from the qualification.
The participants were surveyed a year after completing the program. 97% agree that the program has better equipped them to carry out their duties. 56% have undertaken some other form of continuing education since completing the program.

**Innovation**
The program was an innovative way to better equip staff to carry out their duties, provide training and achieve a qualification without expending budget allocation.

**Applicability to Other Settings**
The program was so successful that a second submission was made and granted and the program has been rolled out to Nepean Hospital. With the same level of commitment from staff, and the leadership team, the program could be used in other hospital settings.
Management, Storage, Retention and Destruction of Secondary Storage Clinical Records
Murwillumbah District Hospital, Clinical Information Department, Murwillumbah, NSW

Author(s)
Karen Kemp Manager Clinical Information Department
Janelle Kaehler Medico legal clerk
Julie Daley Medical Records Coder

Aim
Implementation of new clinical record management practices in secondary storage areas to promote more efficient and effective future retention and destruction processes in accordance with the New South Wales General Disposal Authority (GDA17) (05/04).

Abstract
Historically, patient clinical records have been held in accordance with the relevant NSW GDA. The revised GDA17 will assist users in determining the appropriate retention period for clinical records in public health organisations to better plan for the management and storage of health care records to meet their operational, regulatory and accountability requirements.

Twenty-eight years (28) of secondary storage records (1968-1995) were assessed by Murwillumbah District Hospital Clinical Information Department for retention or destruction, with six (6) years (1990-1995) being reviewed for eligibility for destruction for the first time. Three (3) years of records (2003-05) in the deceased storage area were to be assessed for retention or destruction for the first time.

A comprehensive cull/retention proposal regarding the need for the culling project was provided to the hospital Executive Officer during February 2005 as additional resources of one full time equivalent staff member would be required to undertake the project for the 12 month period.

To improve the efficiency and effectiveness of future destruction/retention processes a detailed Destruction/Retention Schedule for 1968-2031 was developed for use as the reference document. For each record retained, the correct retention year was determined as per the Destruction/Retention Schedule. The retention year was recorded on the “Retain Until…….” label; the label was adhered to the bottom right hand corner of each record and the record refiled. Records for permanent or lengthy retention had a “Do Not Destroy” label adhered to the top right hand side of each record and the record refiled.

An overall total of 24,709 records were reviewed over a 12 month period consisting of 12,669 secondary storage / deceased storage records that were securely destroyed and 12,040 records retained.

This enabled 12,000 or four (4) years of primary storage records to be relocated to secondary storage to provide adequate space in primary storage for current records.

Approximately 4 years of storage space is now available in primary storage, which assists with ease of access for retrieval and filing of clinical records.
Application of EQuIP Principles

Outcome

- A total of 24,709 records were reviewed, of which 12,669 (51.2%) were securely destroyed and 12,040 (48.8%) were retained. Forty (40%) of the retained records were identified for permanent retention.
- For each record retained, the correct retention year was determined as per the Destruction/Retention Schedule. The retention year was recorded on the “Retain Until ….” label. This label was adhered to the bottom right hand corner of each record. Records for permanent/lengthy retention had a “Do Not Destroy” label adhered to the top right hand side of each record.
- The destruction of 51.2% of records in secondary storage has facilitated ease of access for retrieval and filing of clinical records to promote rapid retrieval for continuing patient care.
- Significant cost savings of $33,500 have been made following the introduction of the Cull/Retention labelling system reducing the time taken for the cull from 12 months at a cost of $40,000 to 6-8 weeks costing $6,500.

Consumer focus

- The significant cull of clinical records in secondary storage and re-labelling of bays will improve the efficient record retrieval for all staff, including after hours staff e.g. Assistant Director of Nursing, evening supervisors and reception staff.
- Ease of access for retrieval of records assist to ensure that the clinical record is promptly available to clinicians for patient care, and OH&S principles maintained.

Effective leadership

- A comprehensive cull/retention proposal regarding the need for the culling project was provided to the Executive Officer during February 2005 as additional resources were required to undertake the project.
- The Clinical Information Manager was involved in the project proposal development; the planning of the project; the management of staff resources; the development of guidelines for Cull/Retention Schedule; as a point of reference for clarification and in review of statistics for planning purposes.
- A comprehensive Clinical Record Retention Schedule has been developed by the Clinical Information Manager for record management purposes for 2006 to 2031.

Continuous improvement

The ongoing need for space for clinical record storage indicates that the destruction/retention process needs to be performed annually in order to ensure:

1. adequate storage space for clinical records
2. risk management to minimise the potential for OH&S issues for staff
3. promote ease of access for rapid retrieval of records for patient care.

As a result of the comprehensive labelling process undertaken it is planned to perform annual secondary storage culls and bi-annual cull and re-filing of records from primary storage to secondary storage.

Striving for best practice

The implementation of adhering “Retain Until ….” or “Do Not Destroy” labels to existing secondary storage records, as per the Murwillumbah District Hospital Clinical Record Retention Schedule, in order to expedite future culls, has not been undertaken within the North Coast Area Health Service (NCAHS).
Innovation
The new record management practices introduced demonstrate a new and improved approach to more effectively and efficiently manage the retention and destruction processes at Murwillumbah District Hospital.

References
- NSW Department of Health "Privacy Manual" version 2, 2005
**Manning Waste and Environmental Management Program**
Manning Rural Referral Hospital, Hotel Services Division, Taree, NSW

**Author**
Darcy Elbourne Hotel Service Manager

**Aim**
The Waste Management Plan commenced a process of a concise mechanism for reporting and monitoring the operations of waste on the Manning site to achieve a long term plan of reducing landfill volumes and redirecting the wastes into their appropriate waste streams and increasing recycling.

**Abstract**
The management of waste in hospitals is a significant environmental challenge. At the Manning Hospital, it provides a broad range of specialist services to the residents of Greater Taree, Great Lakes and Gloucester Local Government Areas. The hospital treats approximately 12,000 inpatients and 20,000 Emergency Department patients each year. In providing this service the facility generates vast amounts of waste and rather than send it to landfill, the Waste Management Plan identified opportunities to support and promote the waste management hierarchy of avoid, reuse and recycle. This initiative was for the most effective way to divert recyclable items out of the general waste stream, thereby reducing the volume of waste going into the local landfill and enhancing many of the recycle and reuse practices across the campus.

**Application of EQuIP Principles**

**Consumer focus**
- To change in practice and to motivate consumers to separate the waste at point of generation.
- The chosen strategy was considered the most effective for the removal of trade waste from the facility which was considered economical with the costs associated with alternate strategies.
- The long term customer focused outcome was closely monitoring of the operational procedures and providing feedback and recognition to the staff their achievements.
- The daily exposure of the local and surrounding community groups, either attending the facility as a patients or visitors significantly impacts on the resources to ensure best practice in waste management practices.
- The hospitals housekeeping department is committed and plays a significant part in maintaining high standards of cleaning and waste management to meet the community’s expectations.

**Effective leadership**
- The development of the Waste Management Plan and its implementation to maintain the compliance in the volumes of waste in the various waste streams.
- The Staff have given the process the stamp of approval at Manning with their commitment to and their support for the strategic change in waste management practices.
- The subsequent success and sustained improvement also indicates committed leadership.

**Continuous improvement**
- The ongoing monitoring of recycling improvement rates and the associated outcomes in reducing volumes of waste going into landfill.
- The modifications to operational procedures to increase efficiencies and effectiveness in the management of Sharps waste.
The Manning Hospital is constantly reviewing work practices and operational procedures in the handling of all waste category’s to ensure best practice and compliance to ensure waste is managed with reference to the relevant standards and code of practice.

Outcomes
• There is significant decrease of waste volume (55%) sent to landfill.
• The paper and cardboard recycling rate increased from 49 to 118 tonnes an increase of 140% in one year.
• Savings in landfill space from 155 to 381 cubic meters an increase of 231%
• Consistent annual Numerical Profile score “A”.
• Manning’s Waste Management results provided the Department of Environment and Conservation a “Case Study” for the NSW Government Waste Reduction and Purchasing Policy (WRAPP) for the 2006 Progress Report.
• Keep Australia Beautiful (NSW) Tidy Towns program in 2006. This resulted in being awarded as “Highly Commended” in the population category of 25,000+.
• June 2007 ACHS Accreditation Survey at Manning in Criterion 3.2.3 Waste and environmental management supports safe practice and a safe environment achieved the Rating: OA The organisation is recognised as a leader in the safe and consistent management of waste.

Striving for best practice
• Manning Hospital is a major institution on the Lower North Coast of NSW, it plays an integral role in the day to day life of the Community. This fact is very much taken into account when the waste management plan was developed and implemented.
• Community perceptions regarding hospital waste and the need to gain community stewardship for the practices established was essential for the programs success.
• The Manning Hospital is recognised as a leader in the safe and consistent management of waste. The Waste Management Plan is an exceptional example of a well planned and successfully executed waste minimisation initiative.

Innovation
• The implementation of a unique campus newsletter “Garbage Goss” which provided information and tips on better recycling and waste management practices.
• The newsletter, which is now available electronically to some 14,500 staff across the entire HNE via the intranet.

Applicability to Other Settings
The program looks at all aspects of the waste streams and much of this information can be showcased to the community and other health facilities.
Medical Registration and Medical Indemnity Insurance Compliance
National Capital Private Hospital, Nursing Executive, Garran, ACT

Author(s)
Jolanda Evans  Executive Secretary (Credentialing Privileges Coordinator)
Leanne MacKinnon  Deputy Director of Nursing

Aim
To streamline and achieve one hundred percent compliance that all credentialled Medical Practitioners at National Capital Private Hospital have provided evidence of current Medical Registration and current Medical Indemnity Insurance.

Abstract
National Capital Private Hospital requires all credentialled Medical Practitioners to provide copies of current medical registration and medical indemnity insurance to the hospital and credentialing privileges coordinator each year.

Healthscope By-Laws (June 2006) state that without current documentation the hospital must terminate the respective Medical Practitioners clinical privileges. This is supported by Australian Standards to ensure safety and quality in health care.

To achieve one hundred percent (100%) compliance, letters were sent, phone calls made, letters and phone calls were repeated two to three times. A solution to this time consuming process was required.

The ACT Medical Board and the Medical Insurance Companies require written permission from each individual Medical Practitioner stating that the hospital can obtain this personal information upon request.

A letter/form was drafted requesting permission from all Medical Practitioners at National Capital Private Hospital (NCPH) to obtain their personal information highlighting the importance of current documentation and the benefits to them of giving permission to the hospital to obtain this documentation on their behalf on an annual basis.

Once the forms are returned the hospital will have a streamlined, fast, formal process to achieve one hundred percent current documentation for medical registration and insurance of all medical practitioners credentialled at NCPH.

Doctors requesting clinical privileges will receive this letter on application.

Application of EQuIP Principles

Customer focus
Achieving one hundred percent of credentialled medical practitioners having current Medical Registration and Medical Indemnity Insurance ensures exceptional standards in safe practice and quality in health care are provided at National Capital Private Hospital.

Effective leadership
• This simple but effective change in process demonstrates leadership and provides a process that many health care facilities may adopt.
• It may also be adapted to other areas internally that require total compliance such as nursing registration.
Continuous improvement

- This project is an example of continuous improvement where an issue requires addressing, a solution is proposed and implemented and will require ongoing assessment.
- It will ensure quality health providers at NCPH.

Outcomes

- Are easily measured as annual compliance of one hundred percent is required.
- Those who do not give permission on this occasion will be given further education and opportunities to take up this offer on the next occasion that Medical registration and Medical indemnity Insurance are required to be forwarded to NCPH.
- All medical practitioners requesting clinical privileges will be afforded this opportunity also.
- The number of medical practitioners who have agreed to this change already have significantly decreased the time required to achieve this standard.

Striving for best practice

National Capital Private Hospital strives for excellence as evidenced here by addressing an issue, changing a process in order to improve performance and achieve required standards in health care.

Innovation

- This simple but effective change will assist with compliance at National Capital Private Hospital.
- It is creative it is innovative.

Applicability to Other Settings

- This project can easily be adopted by other health care facilities.
- It may be adapted to other areas of compliance both associated with health or related areas that require gaining documentation from other agencies on behalf of someone else an example perhaps being Nurses Registration.
Moving with the Times: Implementation of an Electronic Booking System for the Clinics
Calvary Health Care Sydney, Clinical Information Service, Kogarah, NSW

Author
Evi Giameos Clinical Information Manager

To successfully implement the Area electronic booking system previously not achieved allowing for better work practices, patient care and accurate data.

Abstract
Goals & Objectives
• to reassess & set-up clinic structure to best reflect services at Calvary Health Care Sydney
• to train staff
• to standardise practice in line with Area initiatives & processes; and
• to streamline reporting of activity.

Identified Problems
• There was limited support to the clinics in the previous attempt to implement.
• There was no previous on-site knowledge of electronic booking systems.

Strategies & Methods
• A gap analysis of the set-up was done to identify areas requiring change. This was then compared with the best practice of the Area and modified. It was tested on a training environment prior to it’s set-up in the live environment.
• A knowledge test was performed on the staff to identify areas requiring training. One-on-one sessions were held with each staff member and practice time was allocated away from the cold-face of the clinics to allow for use of the product and assist in the mandatory data entry required to be in for the system to go-live. Sheets of no longer than 2 pages with simple instructions for quick and easy reference were created to use rather than bulky lengthy manuals.
• Meetings were held to determine reporting requirements and existing practice. It took 2 days each month to complete the statistics manually compared to 3 hours using the reporting functionality within iPM. It was also identified that iPM could provide further ad hoc reporting functionality and the ability to export and manipulate the data.
• The manual diaries were phased out the week before the go-live date to allow for a gradual change and greater comfort in the system.
• The Clinical Information Manager was based in the clinics for the first week of go-live to assist with any issues.

Outcomes
• Clerical staff had access to the appointments on-line simultaneously allowing for faster service to patients. They were able to assist 2 patients at the same time rather than the previous 1 patient at a time therefore reducing the delay of bookings by 50%.
• Stringent rules programmed into the clinic set-up helped with better consultative time between clinician and patient as they were not rushed for time – an more accurate reflection of clinician time in clinic was also able to be identified.
• Clerical staff are able to identify exactly where a medical record is located for a future appointment via a report decreasing the time by 2 minutes per record required to look for
records. With having approximately 60 bookings per day and a third of the records they need being out of their department, this saved them a total of 40 minutes in looking for records.

- There has been an increase of approximately 5.2% in the activity being reported due to the ability to record patients who attend with no appointment booking whereas in the past they were not documented anywhere.

Application of EQuIP Principles

Customer focus
- Faster and accurate information is available at hand for clinicians to more effectively treat patient.
- Patients are attended to in a quicker time frame by clerical support.
- Clinicians can adequately plan and manage their time better.

Effective leadership
Has given confidence to staff in management that they are working towards bettering work practices.

Continuous improvement
- Has increased the support for clinical staff to better patient care.
- Has identified further areas of improvement such as the billing in the clinics.
- Has improved the clinic follow-up process of inpatients from the Rehabilitation ward as their appointments are booked before they are discharged from hospital. The increase in this has been around 80% better bookings.

Outcomes
- More accurate reporting of the activity which has shown an increase of patients being treated.
- Less time required to look for medical records due to exact identification of their location.
- Better consultative time between clinicians and patients.

Striving for best practice
Being an area system it has allowed us to compare, evaluate and learn from the other hospitals in our Area Health Service.

Innovation
The implementation of the electronic booking system has forced the clinics to be accurate in their work practice. Clinical staff treating patients have computers in their rooms and are checking to see when patients have arrived making the patient thru put easier to manage and more accurate. Data is managed more efficiently as the Clinical Information Manager is able to run daily reports to audit the data and follow up errors. With all the hospitals in the Area using the same system we are able to benchmark and compare activity and statistics easier as the definitions used to collect and report data is the same.

Applicability to Other Settings
The implementation of the electronic booking system in the clinics has led to the possibility of its implementation in other non-admitted areas of the hospital. The areas being looked at are group activities held within allied health areas and the community.

It has helped provide the framework for small scale electronic implementations and the basis towards the implementation of the electronic medical record.
NEWSFLASH – Recycling Rejected RO Water in the Home and Hospital
Royal Brisbane & Women’s Hospital, Renal Services, Internal Medical Services, Herston, QLD

Author
Renal Services Department

Aim
Enable recycling of rejected RO water allowing efficient use of utilities thereby protecting the environment for a sustainable future.

Abstract
In a drought environment, the RBWH Home Dialysis Unit investigated the feasibility of capturing rejected Reverse Osmosis (RO) water for recycling purposes. Meetings were coordinated with key stakeholders. Reviews of Haemodialysis water processes and analysis benefits were undertaken. Approval was granted for the collection of rejected RO water, into a tank system, for use on gardens/lawns. Approval also covered the collection of rejected RO water for dialysis units. A Newsflash was generated for the State of Queensland by the Plumbers and Drainers Board. The RBWH now has several home dialysis patients and a Satellite Unit recycling water. Major capital works are planned for our main dialysis unit which will enable us to capture 3.5 million litres of water per year to recycle within the hospital (planned for cooling towers and grounds). Our Independent Unit is installing tanks to enable recycling and all new development sites now include this component in the design phase.

Application of EQuIP Principles

Customer focus
The benefits of extended hours haemodialysis is well-documented and evidenced – improved health, quality of life and cost benefits to health organisation. The ability to enhance these benefits further and revitalise their home lifestyle through water conservation is reported as extremely satisfying by patients who have undertaken this option. As demonstrated in attached article - Mac Vines (first patient undertaking option) states this has returned the gift of freedom for him “It’s been absolutely wonderful for me and it’s given me my life back again.

Effective leadership
• Cooperative working relationships and partnerships are a strategic imperative to ensure optimal use of resources. Cooperative working relationships with a multidisciplinary team of professionals within and outside the organisation are essential to achieve an integrated individualised approach to the care of people with renal disease.
• Undertaking a partnership with patients, clinicians and other government sectors to achieve healthier communities and support sustainable management of natural resources within the community.
• Improved wellbeing for patients and broader community is promoted by the service.
• Meeting Queensland Health Strategic Plan 2004-10 for:
  o Healthier partnerships – working with multiple sectors of government to progress water conservation.
  o Healthier people and communities – healthier environments for communities and improved community based chronic disease management.
  o Healthier resources – using finite resources to maximum advantage.
Continuous improvement

- Improvement in patient care options by increasing availability of home based services through the application in rural settings utilising tank water and septic systems.
- Evaluation of existing legislation and application of benefit to the community.
- Extension from individual patients homes to satellite/independent units to main dialysis unit.
- Enabling patients to water recycle at home.
- All new renal dialysis sites to incorporate waster recycling within design phase.

Outcomes

The outcomes within this process are clearly identifiable:

- By working together across government and non government organisations the environment benefits through water conservation. Giving improved partnerships across workplaces.
- The organisation is managing the utilities (water) safely and utilising it efficiently and effectively thereby protecting the environment for a sustainable future.
- The patient is able to utilise the reclaimed water within their own home providing balance to their lifestyle and water consumption.
- Water consumption for home dialysis patients is 2.5 L/min, with 1.5 L/min being product for dialysis and 1.0 L/min rejected. This correlates to 1300 to 2400 L of water recycled per week.

Striving for best practice

- Support of other QLD Health Renal Units for both Home and In-centre water recycling.
- Initiation of home dialysis service in rural setting.
- Plumbers Newsflash promoted water recycling across state.
- Improved patient satisfaction with ability to reclaim lifestyle incorporating water conservation.
- Presentation of outcomes at National level.

Innovation

- This application was the first in Queensland through dual Shire Councils.
- The collaboration between the RBWH, Brisbane & Pine Rivers Shire Council, Scientific Analytical Services, Building Codes Queensland and the Principal Advisors of the Plumbers and Drainers Board demonstrates a use of initiative and pro-active approach to service delivery improvement.

Applicability to Other Settings

The release of the Plumbers Newsflash enabled other dialysis units across the state to initiate similar processes within own Shire Councils. It was progressed from the individual patient homes to satellite and independent units through to main dialysis unit at RBWH. The reclamation of recyclable reject RO water is included in all future dialysis site developments.
Pandemic Influenza - A cough... A splutter... Are we prepared?
Royal Brisbane and Women’s Hospital Health Service District (RBWH HSD),
District Safety & Quality Unit, Herston, QLD

Author
Tami Photinos  Project Coordinator Pandemic Influenza Planning

Aim
Ensure the organisation is prepared to recognise and manage an influenza pandemic when it strikes.

Abstract
Despite extensive control measures, outbreaks of avian influenza in birds continue, including in our region. The World Health Organisation (WHO) has declared that the emergence of an influenza strain adapted to human transmission is more likely now than in the last 50 years. Australia’s close social, economic and trade ties to affected areas increase our risk of exposure with significant health, social and economic consequences.

In June 2006, the Royal Brisbane and Women’s Hospital HSD appointed a Project Officer 0.5 FTE. Over the last 12-18 months extensive planning has been undertaken that will assist in reducing transmission of the pandemic virus strain, to decrease cases, hospitalisations and deaths, to maintain essential services and to reduce the economic and social impact of a pandemic when it strikes. This submission provides an overview of the current preparedness status.

The project was based on review of evidence, best practice and World Health Organisation recommendations suggesting pandemic preparedness and planning will provide leadership in preventing disease outbreaks and, in the event of an outbreak, the organisation will respond and assist recovery quickly and effectively.

The Pandemic Influenza Committee with the appointment of a Pandemic Influenza Planning Coordinator was formed.

Following a Governance framework, the Pandemic Influenza Planning Committee reported outcomes and any issues to the Emergency Response Committee and the District Safety and Quality Committee. The commitment from Executive ensured that the development of any plans to operationalising in any given circumstances will greatly increase the organisations ability to manage the situation and any risks involved.

Application of EQuP Principles

Consumer focus
Consumers involved with the RBWH Planning to ensure the needs of customers are met include:
- Queensland Health – Emergency Management Unit, Regional planning committees, other hospitals and health care institutions
- Department of Health and Ageing – Australian Government
- Emergency Management Australia
- Queensland Ambulance Service
- World Health Organisation.

Effective leadership
- **Focus on emergency preparedness and early intervention** by developing the RBWH Pandemic Plan to improve processes in recognising and managing an influenza.
• **Demand management** by identifying and influencing demand patterns so that maximum need can be met with available supply including supporting the Pandemic Plan in respect to resource management.

• **Building service capacity** by examining the continuing appropriateness and ability of current mix and distribution of services, improving facilities and services, developing staff to deliver better health services.

• **Whole of government approach** by contributing effectively to the coordinated service delivery and pandemic planning proposals as well as supporting interagency collaboration for particular population and special needs groups and health issues in relation to pandemic influenza planning.

**Continuous improvement**

• **Emergency Desktop Exercises (Exercise Cumpston):** Exercises provide a means to train, practice and confirm necessary capabilities in a less risky environment and to identify and address any gaps.

• **Evidence based delivery** by encouraging continuing professional review of protocols against current research evidence and the most effective interventions pertinent to pandemic influenza planning.

• **Productivity improvement** by enhancing the ability to offer access to a wider range of services provided by dedicated, motivated and highly trained staff during a pandemic.

**Outcomes**

• Pandemic Influenza Management Plan endorsed by Executive

• Pandemic Influenza Intranet Site

• Personal Protective Equipment (PPE) education, training and fit testing

• Antiviral Stockpile of 1000 courses of Tamiflu

• PPE stockpile for 6 weeks

• Cover your Cough and annual vaccination campaign

• Development of Initial Response Centre

• Conversion of emergency rooms to negative pressure rooms

• Installation of Medi-vent filters to increase capacity of exhausted isolation rooms

• Development of fact sheets, brochures, pamphlets and posters

• Extended Respiratory Precaution signs and Travel History signs displayed

• Registrar and Consultant training on taking respiratory specimens

• Pre printed pathology request slips

**Striving for best practice**

• Pandemic Influenza Management Plan provides opportunities for health care providers to develop blueprints that can easily be translated to other organisations on a state wide level with the RBWH seen as a prominent leader in pandemic planning.

• The plan can be used for broader contingency plans encompassing other disasters caused by emergence of new, highly transmissible communicable diseases.

• Although Pandemic / Avian Influenza has occurred in overseas countries, the RBWH has considered health system pandemic preparedness as a priority and never before developed such efficient strategies and comprehensive plans.

**Applicability to Other Settings**

• Major hospitals, regional groups and other institutions have adapted the model of the RBWH Pandemic Plan to assist preparedness planning in their areas.
Quality Management of Food Safety Standards
St Andrews Hospital Inc, Dietary Services Department, Adelaide, SA

Author

Gary Fountain  Manager, Dietary Services Department

• Married with 2 sons, is a Qualified Chef of 26 years experience.
• Gary has been employed within the Health Care Industry for a period of 20 years and has also completed a Diploma of Business Management with Honors in August 2004.
• Gary was instrumental in achieving International HACCP (Hazard Analysis Critical Control Point) Certification for the Dietary Department in April 2006. The Dietary Services has also recently been recognised by winning the 2007 SAI Global Australian Business Excellence Award for Quality Systems.

St. Andrew's Hospital Inc is a 209 bed independent 'not for profit' Private Hospital located at 350 South Terrace, Adelaide, South Australia (ABN 24 589 292 505).

Aim
To provide an exemplary food service to our customers.

Abstract
• A Food Safety Management System for the Preparation, Cooking, Plating, Serving and Distribution of prepared meals to Ward Patients, Cafeteria customers and Staff.
• To minimise food services associated risks to patient safety, the Dietary Services undertook a comprehensive external auditing and verification process.
• External verification and validation of the Food Safety Plan to the Australian Food Standards Code, FSANZ (Food Safety Australia, New Zealand) standards incorporating 7 principles of HACCP as specified in HACCP – Codex Alimentarius CAC/RCP 1 – 1969, Rev. 3 – 2003
• We currently prepare 191,000 fresh cooked patient meals and approximately 73,000 Cafeteria meals per annum.
• St Andrew’s Hospital Dietary Services is currently certified by an International Accredited company, SAI Global. SAI Global is an applied information Services Company that helps organisations manage risk, achieve compliance and drive business improvement.

Application of EQuIP Principles

Customer focus
• St. Andrew’s Hospital provides an opportunity for all our customers to direct their compliments and or complaints in a Patient Feedback form provided on admission.
• Providing an effective, safe and measurable food service provides our customers with ‘peace of mind’.
• To maintain verification and validation of the St. Andrew’s Hospital Food Safety Plan resulting in continued effective risk management through comprehensive auditing system.

Effective leadership
• By implementing the Food Safety Plan, the Dietary Services Manager has demonstrated responsible leadership with a genuine commitment to quality, performance and patient care.
• Our Food Safety Plan offers a strategic opportunity for our employees to be motivated and encourages these employees to contribute effectively through self improvement and effective leadership.
Continuous improvement
- On-going and continued education and training for all Dietary personnel provided by Industry professionals. This is maintained on file and is actioned twice yearly.
- By researching and addressing new and/or revised mandatory Industry Standards through external auditing practices.
- Continuous patient feedback provided by the ‘Patient Feedback Form’ and Consumer Forums identifies areas for improvement.

Outcomes
The process of accreditation and certification has provided St. Andrews Hospital with quantitative and qualitative data to provide evidence that support a quality Dietary Service, incorporating an excellent standard of meals and food safety.

Striving for best practice
- We have applied Best Practice principles within the Dietary Services Department during implementation of our Food Safety Plan and have now obtained HACCP Certification to an International Standard incorporating ISO 19011 Best practice, our Certificate number is HCV 20218.
- On the 21st June 2007, the Dietary Department received a prestigious Australian Business Excellence Award 2007 for Quality Systems.

Innovation
In the interest of patient safety and risk management, St. Andrew’s Hospital as market leaders agreed on a strategic plan to implement and externally Certify the Food Safety Plan, this is currently not a legislative requirement or a typical Industry practice.

Applicability to Other Settings
This Food Safety system is specific to any Dietary system which is applicable in Health care or any other areas where food is prepared and consumed, the outcomes are measurable, effective and provide evidence for Accreditation.
Reduce Delay in Issue Time of Discharge Summary
Kerala Institute of Medical Sciences, Trivandrum, Kerala, India

Aim
To reduce the discharge summary issue time to less than 3 hours for all departments.

Abstract
The project aims to improve patient satisfaction by reducing the discharge summary issue time (The time when the nursing station informs the Department of Medical Transcription till the issue of ‘discharge summary’ to the nursing station was taken for the study) to less than 3 hours for all departments through effective and systematic methods, which in turn will help the organization to meet its quality objectives. As Patient Counsellor got remarks from patients about the delay in getting Discharge Summary, the Department of Medical Transcription analysed and compared the Discharge Summary Issue time of various departments. From that it was observed that most of the departments are taking more than 6 hours to issue discharge summary, which causes many difficulties for the patient. So a project was undertaken (Period – 4Months) with the main objective of reducing delay in Discharge Summary Issue Time. The Department of Medical Transcription handles the issuing of Medical Certificates, Discharge Summary Report, Angiogram report and Referring letters. The department receives online and handwritten summary from clinicians.

Data Collection
Primary data collected from Discharge Summary detail sheet and direct feedback from patients to Patient Counselor during daily rounds. Population was the total number of discharges/month (July 2006 – 1504, October 2006 - 1480). The departments taken for the project include General Surgery, Gynaecology, Internal Medicine, Neurology, Neurosurgery, Orthopaedics, Paediatric Surgery, Paediatrics/Neonatology & Plastic Surgery.

Initial study showed that departments take more than 4 hours to issue discharge Summary include General Surgery, Orthopedics, Internal Medicine, Gynaecology & Pediatrics/Neonatology.

How did the team go about their task, how long did they take

• Project team did a brain storming session.
• Prepared cause and effect diagram & Fishbone (Ishikawa) diagram.
• Prepared a detailed process flow chart.
• Identified data measurement points.

Problems Identified
• Lack of discharge planning.
• Underutilization of Online Discharge Summary.
• Consultant writing the discharge summary only after their outpatient clinic time.
• Draft summary sent again to consultant in OP for correction.
• Delay in indenting the Discharge Medicine.
• Lack of option to copy lab reports – Time lost in keying in the reports again.
Implementation & Evaluation

- Discharge planning initiated.
- Online discharge summary initiated.
- The statistics was shown in Doctor’s meeting, so that they realize the actual picture and difficulty faced by the staff.
- All Discharges taking more than 4 hours were reported to Management for action.

Outcome

- The average time taken of discharge is higher while taking the project and it was about more than 6 hours. Here its shows remarkable improvement in majority of the departments.
- The Departments with maximum average discharge Summary issue time were General surgery & Orthopaedics for which the time shows a significant reduction.
- Average discharge time decreased from 6 hrs (July 06) to 3 hrs (Oct 06).
- Complaints regarding delay in discharge are immensely reduced after taking it as project. This shows that the patient satisfaction has increased.

Application of EQuIP Principles

**Consumer focus**
- The objective was to reduce delay.
- Improve patient satisfaction by reducing waiting time after discharge.

**Effective leadership**
- Effective participation of staff from various departments (Department of medical Transcription, nursing, doctors, Quality Systems, Information Technology & Safety Department).
- Brainstorming sessions.
- Project team – multidisciplinary (Pathologist, technicians, Quality personnel & surgeons).
- Discussion about statistics in monthly Doctor’s meeting.

**Continuous improvement**
- Monthly Performance indicator on delay in discharge summary issue time.
- Discharge planning form initiated and compliance to the same is monitored.

**Outcomes**
- Discharge summary issue time reduced from 6 hours to 3 hours.
- Significant decrease in the patient’s complaints counselor regarding discharge delay (41% in June 06 to 5% in November 06).
- Waiting time of patients after discharge reduced.

**Striving for best practice**
- Software reformation and less errors.
- Introduction of Electronic medical Records.

**Innovation**
- Discharge planning form for doctors and nurses.
- Online summary with the help of existing telephone lines through 2 dedicated lines.

**Applicability to Other Settings**
- Availability of Online data helped other departments like Insurance Desk for report submission to authorized personnel.
- Doctors started using Electronic Medical Records more frequently.
- Errors in discharge summary came down due to online corrections.
Rights and Responsibilities - Addressing the Expressed Needs of Consumers Using 6 Sigma Methodology
Peninsula Health, Clinical Governance, Quality and Customer Services, Frankston, VIC

Author
Elaine Bennett    Director of Clinical Governance, Quality and Customer Services

Aim
To address the expressed needs of consumers as regards provision of Rights and Responsibilities information.

Abstract
Peninsula Health (PH) provides a comprehensive range of health care services to over 300,000 people in Frankston and the Mornington Peninsula. The Health Service has a Health Service Care Charter that seeks to provide a clear explanation of expectations that is understood by both service users and also health care providers.

The Health Service undertook a range of initiatives to raise consumer awareness of Rights and Responsibilities (R and R). These included posters prominently displayed at all locations and leaflets given out by staff to all consumers on admission. Audits undertaken at regular intervals verified that the R and R message was being given routinely to consumers. This was validated by Victorian Patient Satisfaction Monitor feedback which demonstrated PH performance was above state average at all locations.

In further evaluating its performance on R and R, Peninsula Health sought direct feedback from its consumers and also staff who were responsible for providing the information to consumers on admission. Ten focus groups involving consumers and staff were convened to explore expectations, views of performance, awareness and understanding of rights and responsibilities.

Consumer feedback was that >50% of those interviewed by an independent consultant engaged for the task said that PH performance “needed some improvement”.

Consumers commented:

“We need to have things explained simply. Sometimes we are embarrassed to say ‘repeat that I didn’t understand’.”

“Ideally I’d prefer someone to sit down and talk to me one to one”

“It’s too wordy!” (A reference to the R and R leaflet given routinely to consumers)

Staff commented “consider using community volunteers to assist us”.

In June 2006, feedback from these sessions was used to inform a quality improvement project using Six Sigma quality improvement methodology. The aim of the project was to improve consumer perceptions of PH performance in provision of R and R information.

The outcome of the project was:
• The redesign of consumer information (using a readability index) to make the content simpler and clearer.
• Production of a poster using symbols instead of words (also produced as a postcard with a feedback section on the back).
• A trial whereby trained community volunteers delivered the message verbally using the new format information and postcard.
• Increased consumer satisfaction as compared to baseline levels ascertained at the focus groups.

Application of EQuIP Principles

Consumer focus
• Project initiated to address the directly expressed needs of consumers at focus groups.
• Outcome was a trial involving trained community volunteers to deliver the R and R message using enhanced information leaflets/posters.

Effective leadership
• Project strongly supported by the CEO.
• Project sponsorship by an Executive Director.
• Multidisciplinary team convened to deliver tools and techniques to achieve improvement in predetermined short time frame.

Continuous improvement
• PH had independent evidence that its performance on R and R (awareness) was above average.
• Further enhancement was nevertheless sought by this innovative organization.

Outcomes
• Consumer satisfaction with PH performance on R and R increased following the intervention from >50% expressing that it was in need of some improvement beforehand to 85% patients saying that they were highly satisfied.
• Sustainability evidenced by the continued use of the volunteers and enhanced R and R information.

Striving for best practice
• Innovative approach showcased to positive feedback and requests received for further information at:
  o Victorian Healthcare Association Conference, October 2006.

Innovation
• The use of trained community volunteers to verbally deliver the health service’s Rights and Responsibilities information direct to consumers.
• The use of symbols to describe Rights and Responsibilities alongside the usual wordy approach for the benefit of consumers.

Applicability to Other Settings
Applicable to all health care delivery settings
Safe Practice Environment - To Establish a Program for Management of Hazardous Substances / Dangerous Goods to Ensure a Safe Environment for Staff and Visitors
North Shore Ryde Health Service, Hazardous Substances & Dangerous Goods Committee, St Leonards, NSW

Author
Dr Anastasia Susie Mihailidou Chair, NSRHS HSDG Committee

Aim
Establish a program for management of hazardous substances/dangerous goods across a health service based on the foundations of best known practice and risk management, using appropriate Codes of Practice and Australian Standards.

Abstract
The program for the management of HSDG’s across the health service was initiated by the NSRHS HSDG Committee following an external review of dangerous goods on site. This review identified 30 tonnes of dangerous goods on the site and provided a report with 139 recommendations to ensure the service was compliant with the Dangerous Goods legislation. Following on from this review and the urgent need to address compliance the NSRHS HSDG Committee developed performance indicators to drive a management program that would pick up these recommendations and assist the NSRHS in remaining compliant with the legislation within the NSW Health Safety paradigm. Direct outcomes of the program include a significant reduction of HSDG inventory, substitution to less hazardous materials where appropriate, implementation of protocols to minimize or eliminate the risks involved in handling these agents to maintain a safe working environment for staff and visitors and achieving a high level of partnership activity with multiple key stakeholders. Application of the program to other health services is high. To further promote best practice an interstate benchmarking project is underway with ACT Health. This will allow the development of benchmarks and enable comparison of practices across the two Health Services to identify strategies to further improve our current practices.

Application of EQuIP Principles

Customer focus
- continued consultation with staff and specialist training is sourced to develop competencies for the management of HSDG’s
- key linkages established with various key stakeholders.

Effective leadership
- collaboration with relevant stakeholders both internal and external to the health service
- implementation of hazardous signage in laboratories and the development and implementation of relevant policies and procedures.

Continuous improvement
- the development and implementation of “Guidelines for Management of Hazardous Spills” to provide a standardized approach to the management of hazardous spills and spill kits, as well as cooperative management strategy between staff and the Emergency Response Teams. Standardized guidelines developed include all hazardous material spills [chemical, radioactive, biological material and cytotoxic] and respective Safe Work Practices (SWP).
- the HSDG Committee has coordinate training for staff handling HSDG’s including training in the NOSHC Code of Practice for Labelling Workplace Substances.
Outcomes

- a register established of all Dangerous Goods Storage Depots as well as all sites handling HSDG’s
- 100% of dangerous goods sites on this register are reviewed annually
- a reduction of 67% in quantities of dangerous goods across RNSH
- increased staff awareness in the management and storage of dangerous goods
- 133 of the 139 recommendations (96%) from the external review have been completed
- initial review of sites handling hazardous substances identified 167 audit findings. 152 recommendations (91%) have been implemented, with annual review revealing a reduction in additional recommendations.
- committee-designed (colour-coded) signs supported by a best practice procedure for the different types of spill kits and distributed these across the Health Service and also distributed to other sites within NSCCH.

Striving for best practice

Development of the benchmarking processes for the management of HSDG’s across the Health Service with ACT Health demonstrates a commitment to providing continuous improvement and applying best practice principles for management of HSDG.

Innovation

Development and implementation of “Guidelines for Management of Hazardous Spills” to provide a standardized approach to the management of hazardous spills and spill kits across a Health Service, as well as cooperative management strategy between staff and the Emergency Response Teams.

Applicability to Other Settings

The program for the management of HSDG’s can be easily applied to other health services as well as external agencies.
Sick Leave Donation Registry
Northern Health, Diversity Management Committee, Epping, VIC

Author
Barbara Hart  Senior Employee Relations Consultant, Northern Health

Aim
The registry is designed to assist employees who are experiencing financial hardship due to a catastrophic illness or injury suffered by them or a member of their immediate family and the exhaustion of paid sick leave entitlements.

Abstract
The Northern Health Diversity Management Committee determined that there was a need to support employees who after a catastrophic injury or during a chronic/terminal illness were experiencing financial hardship due to a lack of sick leave. A proposal was put forward to the Northern Health Executive in March 2005 to implement a Sick Leave Donation Registry as a pilot program for a period of twelve months. The organisation conducted an evaluation of the pilot program in March 2006 and the registry was endorsed as an ongoing program.

Our staff have embraced the introduction of the registry with high levels of donations.

Application of EQuIP Principles

Outcomes
• Twelve employees have been granted a total of 4029 hours from the registry.
• Our employees have donated 7997 hours to the registry.
• The registry has a healthy balance of 3968 hours.

Customer focus
• This initiative meets the Executive’s requirement for Best Practice Human Resource Management.
• Staff were briefed on the introduction of the registry through information sessions across all campuses, e-mail, newsletter, and information attached to their payslips.
• Human Resources completed a survey in May 2007 on our Employment Assistance Program where 91% of respondents were aware of the Registry. Staff were very positive with their comments on the registry.

Leadership
• The CEO has been pivotal in ensuring that the registry was endorsed as an ongoing program across Northern Health. The Northern Health Executive has endorsed this initiative knowing that there would be a financial cost to the organisation.
• Staff have embraced the registry by donating their sick leave which has enabled us to provide leave for employees who are experiencing financial hardship at a time of illness or injury.

Continuous improvement
• Northern Health wants to promote itself as an employer of choice and this is another innovative proposal.
• This initiative increases employment condition flexibility and recognises work/life issues by extending the program to include hardship that may arise from the catastrophic illness or injury of an immediate family member, where an employee has had to utilise all their own sick leave to attend to the medical and/or treatment needs of their family member.
• The program continues to strengthen the sense of community among Northern Health employees – looking after and supporting each other – just as we are doing with our patients and the communities in which we live and work.
• The program has been evaluated and has met its aims and objectives.

**Striving for best practice**
• The registry was commended by the surveyors during the accreditation of the Northern Hospital in November 2006.
• The registry won the Corporate Northern Health Quality Award in April 2007.
• We have been contacted by five health services in Victoria and two Local Councils seeking information on the implementation of the registry.

**Innovation**
We are the first health service in Victoria to implement this innovative project.

**Applicability to Other Settings**
• A number of health services have requested information on the registry with two metropolitan health services in the process of implementing a registry.
• This project has applicability in health services as well as other sectors.
Squirming Our Way to EA!
Northeast Health Wangaratta, Quality and Safety, Wangaratta, VIC

Author(s)
Michelle Butler  Quality & Safety Manager
Angela West   Quality Coordinator

Aim
To encourage staff to view quality and accreditation as “usual business”.

Abstract
In an attempt to raise the profile and to demystify quality, the quality team in a regional hospital in North East Victoria developed a quality theme. This theme was used in promotion, as document headers, on posters and department notice boards and has since entered the vernacular of the organisation. Cost to the organisation was in wages and printing only. The numbers of quality activities have risen significantly, and staff have ownership of quality on a departmental level. Ongoing review and development of the theme, supported with staff education and assistance, resulted in an upgrading by surveyors to an EA rating at the 2007 Periodic Review. Staff commented about the lack of fuss surrounding this last review – the complete opposite of the previous periodic review in 2003. Therefore the project had achieved its aims.

Application of EQuIP Principles

Consumer focus
- Listening and responding to the comments of staff re quality.
- Enhanced involvement of Consumer Advisory Committee.
- Publication of Quality of Care reports.

Effective leadership
- Support for quality team and appointment of new members to the team to progress the objectives of both the organisation and of the quality team.
- Approval to purchase software to improve the quality program.
- Linking of strategic and operational plans to quality plans.
- Priority given to the quality team to present at various meetings and forums across the organisation.

Continuous improvement
- Ongoing evaluation of the various aspects of the quality program.
- Increase in the number of quality activities reported.
- Continuously adapting the program to meet the needs of the staff.
- Ongoing improvement to quality planning as part of operational planning processes.
- Philosophy that quality “begins at home” and program designed to support that message.

Outcomes
- Ongoing review of the quality program by the quality team in conjunction with staff, Executive and community.
- Encouragement and support provided to departments to measure and report their results and data.
Striving for best practice
- Willingness of the organisation to share programs and information with neighbouring health services.
- Organisation ready to lead other organisations in program development – we are the first health care organisation in Australia to use the VigilEnt Policy Management System.
- Willingness of the organisation to be pilot sites for several quality projects that have resulted in improved client outcomes: Effective Discharge Program; Patient Flow Collaborative Program; Falls Management; Pressure Ulcer Point Prevalence Survey; Impaired Cognition Program; and many others.

Innovation
- Development of a logo and mascot without expense to the organisation.
- Using the logo and mascot on all documents, advertisement, posters, etc.
- Supporting the program with prizes, t-shirts, competitions linked to the program’s theme.
- Using games to demonstrate the importance of quality and safety to an organisation.
- Creating level of interest from staff from the outset by running a “SQuIRM is Coming” program prior to launching the program.

Applicability to Other Settings
- Program delivered to two other local health services who used the presentation to develop their own theme.
- Cheap program which any health service (or any business for that matter) could adapt to suit their particular environment. For example, one of the health services we presented to was Rutherglen, one of the major wine producing areas in Victoria. They toyed with the idea of having a half filled wine glass as their theme – is it half empty or half full?
- We developed our theme based on what we had seen in other organisations.
- The idea is not limited by location, service type, size of organisation, cost, public or private facility.
- The major requirements are only ideas, enthusiasm, Executive support and a willingness to listen and respond to staff.
STAR: Support Team Action Response  
St. Vincent’s - Human Resources, FITZROY, VIC

Author  
Jacqui Bloink  HR Consultant and STAR Coordinator

Aim  
To provide a multi-disciplinary peer team to empower St Vincent’s staff to manage their own stress and deal with critical incidents in the workplace.

Abstract  
Support Team Action Response (STAR) is a multi-disciplinary peer team empowering St Vincent’s staff to manage their own stress and deal with critical incidents in the workplace. STAR team members offer information, crisis support and reassurance. They also assist with links to professional support and counselling if required. The STAR approach recognises the challenges of working in the healthcare environment and seeks to support staff, improve workplace performance and reduce the level of stress claims, absenteeism and turnover by ensuring staff are valued and supported.

STAR is a peer support program comprised of staff who volunteer their time, with the support of their managers. It is not designed to replace qualified counsellors but rather to supplement them through front line support by colleagues. STARs are familiar with the counselling and other professional services available and refer staff to these services as appropriate.

STARs come from all areas of the organisation and are available 24 hours a day, on a rostered basis, to listen to and support staff one-to-one or in groups, provide information about critical incident stress management, facilitate group interventions such as defusings or debriefings, and provide early interventions in response to major incidents. In the past two years, a course of quality improvement initiatives and evaluation has lead to increases in team numbers, utilisation rates and referral by STAR to other support services.

Application of EQuIP Principles  

Customer focus  
- Supporting staff as consumers of the STAR Program leads to greater work satisfaction and the capacity to deliver more efficient and sustainable services. Better services mean better outcomes for patients, clients and our communities.
- A workplace in which there are multiple approaches to supporting and empowering staff in stress management helps to build individual and organisational resilience and creates the right environment for high quality patient care.

Effective leadership  
- St. Vincent’s is a recognised leader in peer support and Critical Incident Stress Management in public hospitals. STAR Program Coordinator plays a significant role in promoting STAR throughout the health sector and is a mentor and adviser to new peer teams in Victorian health services.
- Numerous strategies are in place to ensure STAR team members are motivated and supported to contribute to design of the program.
- As a vibrant peer support model, STAR continues to be an important component of St. Vincent’s employee support program with the increasing number of contacts reflecting its value.
Outcomes

• From January 2006 to December 2006, 264 staff participated in STAR group sessions and 123 individuals called on STAR's support. This is a 37% increase from 2004.
• During the same period, STARs made 197 referrals to other services, a 19% increase from 2004.
• STARs have assisted and supported staff in a wide range of situations including death, organ retrieval, assault or threat of assault, health and safety issues and personal issues.
• Turnover and absenteeism rates at St. Vincent's remain below industry benchmarks.

Continuous improvement

• STAR ensures a program of continuous quality improvement that entails identifying opportunities for improvement, maintaining a quality service and monitoring outcomes.
• Education, quality and strategy objectives are set each year and form part of the Program's annual plan.
• In the period 2004-07, numerous quality improvements have been made to the STAR program as a result of evaluation.

Striving for best practice

• St Vincent's STAR training is internationally accredited and benchmarked all training is evaluated to provide opportunity for improvements.
• Evaluation of STAR indicates it continues to be an integral and highly regarded employee benefit and that:
  • staff are aware of the program
  • there is a need for this type of support
  • staff trust the process
  • STAR members are committed to their role.

Innovation

• STAR began with a small number of staff being trained in Critical Incident Stress Management (CISM), an internationally recognised model, first introduced to Australia in the mid-1980s in Victoria's ambulance service.
• STAR program has grown to comprise 80 team members, trained to provide first line support to colleagues, empowering staff to manage stress and deal with critical incidents in the workplace. Other healthcare providers seek to emulate the program.

Applicability to Other Settings

• STAR has great applicability to other organisations and sectors.
• STAR Program Coordinator is regularly contacted by healthcare organisations wishing to implement peer support programs similar to STAR.
The Candidate Care Service Model
Gold Coast Health Service District, Candidate Care Service, Corporate Services Division, Southport, QLD

Author
Angie Norris  A/Candidate Care Coordinator

Aim
To provide assistance for staff relocating to the Gold Coast and candidates who are seeking employment within the Gold Coast Health Service District.

Application of EQuIP Principles

Customer focus
- Assist candidates and their families relocate to the Gold Coast.
- A single point of communication.
- Linking candidates/employees with information relevant to their individual needs.
- Social contact and orientation to local facilities and services e.g. real estate, educational facilities, child care etc.

Effective leadership
- Strong Executive leadership and support for the new service.
- The District Manager is committed to ensuring new staff are provided with the best possible introduction to the District and retention of staff is a priority.

Continuous improvement
- Innovative recruitment strategies were developed e.g. a variety of media options.
- Improved links with Public Affairs in relation to advertising, marketing and branding strategies.
- Attendance at relevant conferences and health care recruitment drives.
- Attendance at recruitment strategy meetings throughout the District to continue to promote the role and to ensure potential candidates are aware of the service.
- Increased awareness and attendance of any recruitment drives throughout the District and Queensland Health so that assistance can be offered to new employees, as soon as required.
- A new process was developed which sees the divisions being responsible for referrals of their candidates to the Candidate Care Coordinator, which ensures an adequate handover.
- The candidate is contacted by the Candidate Care Coordinator, introducing the service and reassuring them that they will be assisted during their transition.
- Future workforce planning assistance for divisions planned.

Outcomes
- Steady referral rates of candidates from divisions.
- Increased level of Occasions of Service by the Candidate Care Coordinator, since the inception of the service.
- A report detailing positive customer feedback about the service.
- Candidates who feel supported and valued.
- A high level of applications for vacancies and expressions of interest within the district.

Striving for best practice
- Future benchmarking to ensure the best service is adopted for the District.
- Assist and retain our most valuable asset for the future, our staff.
- Provision of the required amount and level of care our clients deserve.
Applicability to Other Settings
Applicable to other district’s healthcare settings and other government organisations.
Value and Retain or Lose and Recruit
National Capital Private Hospital, Nursing Executive, Garran, ACT

Author
Leanne MacKinnon  Deputy Director of Nursing

Aim
To value, retain and improve the working life of nursing staff at National Capital Private Hospital.

Abstract
Against a background of business expansion and the need to ensure that employees feel valued, a survey was designed, circulated and is to be analysed to determine what, if any, management responses may be available to improve employees working life and retain their valuable skills in the workplace.

A survey was distributed to all permanent Enrolled and Registered Nurses including Senior Management. The results will be collated, discussed and a program to address issues developed.

Workplace changes will be implemented as a result of the staff input and an ongoing monitoring and evaluation process put in place.

It is hoped that increased job satisfaction will lead to improved retention, commitment, improved customer service and clinical outcomes. There may also be improved occupational health of employees, decreased sick leave, workplace injury, decreased agency use and recruitment needs and a lessoning of the cost associated with these. This will ensure a positive impact on business growth.

Application of EQuIP Principles

Customer focus
• Nursing staff are an essential component of providing quality care.
• Improved workplace satisfaction will improve clinical care and outcomes to patients that nurses care for.

Effective leadership
• Demonstrate commitment to survey through individual time, finance and resources.
• Feedback findings and planned implemented change to employees.
• Employees are one of the principle assets of any organisation.
• To support and lead with a project such as this encourages a motivated, confident, creative, committed and valued workforce.

Continuous improvement
• A project such as this allows many pairs of eyes to see areas of improvement and a voice to contribute to changes required to continually improve.
• Like this survey, further planned follow up surveys will allow the process to be ongoing.

Outcomes
• Evaluation of sick leave, workplace injury, agency use, resignation rates and recruitment needs will be a significant means of establishing the effectiveness of this survey and implementation of workplace changes identified.
• Follow up evaluation with staff will also indicate outcomes.
Striving for best practice
• National Capital Private Hospital strives for excellence in all workplace relationships.
• This project specifically pertains to nursing staff.
• To ask, to listen, to react and implement changes to address issues of importance to this workforce demonstrates our ongoing commitment to strive for excellence in best practice.

Innovation
• This style of project was unique to National Capital Private Hospital in 2005 with a survey “Valued or Burnt Out Business is Booming”.
• Value and Retain or Lose and Recruit is a follow up initiative for 2007, with a survey “How can we at National Capital make your Working Life Better”.

Applicability to Other Settings
• This survey can be utilised across all departments at National Capital Private hospital ie Patient Services Department, Front office and billings department. It can be used for all employees.
• This project can in fact, be utilised for any employee, in any workplace as long as Executive Management are prepared to ask the questions, listen and address all issues raised by employees. This takes commitment and a willingness to strive for best practice.
We’ve Always Done it Like That
Royal Darwin Hospital, Pathology Department, Casuarina, NT

Author(s)
Paul Southwell  Supervising Scientist of Microbiology
Jan Jones  Occupational Health & Safety Consultant, Department of Corporate Information Services, Northern Territory Government

Abstract
Constraints and limitation of resources, common to public hospitals, had resulted in poor compliance with regard to the management of chemicals within Royal Darwin Hospital. Whilst there was recognition that deliberate negligence was not evident, a culture of “we have always done it like that” was accepted practice. An ACHS review in July 2006 was the catalyst for change. In order to effect this culture change a chemical management system was developed, and an implementation trial was undertaken within the Pathology department. The system was underpinned by a comprehensive plan to direct and guide employees in the use of products, purchase, transportation, safe storage and handling, training, personal protective equipment and disposal of all hazardous and dangerous chemicals. The time frame was 90 days.

Aim
To adopt a change focus management for the safety management and control of hazardous chemicals used in a Pathology Laboratory.

Application of EQuIP Principles

Customer focus
- Implementation of the Chemical Management Plan for Dangerous Goods and Hazardous Substances (see appendix XXXX) that provides information and direction to ensure the health and safety of patients, visitors, staff and contractors are protected when working with, or in proximity of dangerous goods and hazardous substances within the Royal Darwin Hospital.
- An efficient managed program minimises risks to the local environment.
- MSDS – training, use and availability to staff in an electronic format.
- Correct disposal methods for unwanted hazardous substances and containers.
- Safe transportation methods of hazardous substances.
- Improved Hazardous substances administration.
- Improvement in the level of emergency countermeasures currently in place (signage, chemical cupboards).
- Management control of chemicals lowers the potential risks to all handlers in Pathology.

Effective leadership
Senior management:
- Commitment was vital to the success – an open and participatory management style (demonstrated by the Operational Manager and General manager, demonstrated evidence of this commitment which had appositive outcome, i.e., a plan and a chemical management policy was written and implemented within a ninety day timeframe.
- The General Manager was committed to a defined strategy (i.e., the plan).
- The implementation strategy addressed the timeframe, resources (i.e., purchase of ChemAlert software), training and maintenance structure (additional safety cabinets, safety signage etc).

Middle management
- The Quality Team, the Pathology rep and DCIS OHS Consultant were instrumental in communicating the chemical management vision of senior management. This was achieved by encouraging active participation in the plan (by the Quality team and DCIS OHS Consultant);
ownership of the ChemAlert software by the Pathology Rep; measurement of and the feedback on quality outcomes (Recognition of the disposal of chemicals, and the general work in complying to Australian Standards).

Continuous improvement
- The implementation of a plan, meant that improvement efforts were plan driven and not event driven. This plan allows for continuous improvement. See appendix XXXXX
- By performing this exercise there was evidence of RDH experiencing a cultural shift. This was the beginning for real change in which a proper audit system was initiated, and thus a frame work for quality management could flourish.
- A regular audit system will allow to measure and monitor hazardous chemical in Pathology, with the view to eliminate chemicals that are not regularly used.
- This audit system was implemented in Pathology, was deemed to be successful, and thus a roll out policy to introducing this system to other high-risk areas e.g., pharmacy. This model will also be used for other hospitals in the NT.
- The audit system will monitor handling of hazardous chemicals in Pathology, thus allowing safety.

Outcomes
Demonstrated outcomes include:
- Pathology experienced a cultural shift, which resulted in a safer working environment.
- Each section in Pathology that handles hazardous chemicals, have relevant, current MSDS. A prudent attitude now prevail in regards to the control of chemicals in which much more effort is made to be informed about risks and reduction minimisation.
- A chemical management control database is now in existence in Pathology.
- Correct and relevant warning signage.
- Correct disposal management of chemical waste – “down the sink” disposal, for example is no longer routine. 158 chemicals were totally removed from Pathology; which equates to over 12 kilograms and 26 litres of fluid. Chemicals were disposed off via chemical waste management contractor.
- Correct situation of safety cabinets (Flammable, corrosive and explosive).
- Correct storage of explosive chemicals.
- Monthly monitoring of cabinets.
- Reduction/elimination of chemicals.
- A formal system for management of all aspects of Hazardous Substances.

Striving for best practice
- Implementation of state of the art technology (ChemAlert software).
- This technology has been adopted by other NT laboratories to control chemicals.
- Having a chemical management policy improves the safety for the operator.
- A network for chemical control is being established, re advice on chemical storage, handling and disposal.
Youth and Road Trauma Forum 2007
Sydney West Area Health Service, Westmead Hospital Trauma Service,
WENTWORTHVILLE, NSW

Author
Stephanie Wilson  Sydney West Area Health Service Area Trauma Coordinator
Julie Seggie  Westmead Hospital Trauma Coordinator

Aim
The aim of the forum is to reduce the mortality and morbidity of our youth via engaging road safety education and to provide information that empowers them to make safer choices.

Abstract
The youth and road trauma forum’s primary objective is to reduce the fatality and injury rates of young people and to ensure that the community is aware of injury prevention, trauma care services and related resources available.

The forum is a one-day program run over 3 days that includes a real crash scenario; a variety of interactive displays, lectures, demonstration and guest speakers who have themselves suffered serious brain and spinal injuries due to road trauma. Students gain an understanding of the responsibilities involved with driving and witness and experience first hand, the potential risks associated with driving and being a passenger. This is road safety being delivered in an engaging and dynamic manner.

NRMA Motoring & Services as a non-government agency applauded the initiative and has partnered with us for the last two years to provide an integrated approach to planning and funding. They also brought their expertise on car and tyre safety, safe stopping distances, car safety features and youth membership.

Invitations are extended to all government and non-government high schools in NSW and the ACT. In 2005, 464 students attended from 10 local high schools. 2006 saw 4000 students attend the forum over 2 days from 31 schools across NSW and the ACT. 2007 had 10,000 students attend from 86 high schools across Sydney, NSW and the ACT.

The total cost of running the forum is $220,000.00 and was divided between Westmead Hospital Trauma Service and NRMA Motoring & Services. This works out to be a cost of $22.00 per student. The forum was free to the students and schools and the only cost to them was in transport to and from the event and lunch.

Evaluation forms are given to both students, teachers and stake holders to assess the benefits of the forum and to evaluate the effectiveness of changing the behaviour of our youth in regards to road safety. Encouraging results followed with 98% of the students stating they would change their behaviour on the roads.

Application of EQuIP Principles

Customer focus
- Teachers continue road safety education in the classrooms following the forum.
- Follow up visits to schools
- Evaluation forms given to teachers to assess the forum and adapt the program where suitable to fit in with the Physical Health and Physical Development Education Program (PDHPE)
- Students are provided with engaging road safety education and information that empowers them to make safer choices.
- No cost to students or schools to attend the forum.
**Effective leadership**
- Formation of committee with support by Sydney West Area Health Service
- Regular meetings with key stakeholders to address ideas, strategies and development of the program.
- Clear lines of responsibility
- Formal and informal contracts drawn.
- Formation of a strong partnership with NRMA Motoring & Services.
- Formation of a strong working relationship with both government and non-government organisations.

**Continuous improvement**
- Financial support from the state and federal government is currently being sought and this will ensure continued sustainability of the forum.
- Schools are sending years 10 and 11 students to attend and repeating this each year so a critical mass is being educated.
- Stakeholders are encouraged to offer suggestions and ideas to allow the forum to better focus its content and continue to grow.

**Outcomes**
- Evaluation forms are given to both students, teachers and stakeholders to assess the benefits of the forum and to evaluate the effectiveness of changing the behaviour of our youth in regards to road safety.
- 98% of the students who attended the forum state they would change their behaviour on the roads.
- Nominated for the Prime Ministers Partnership Awards 2006.
- Winners of the NSW Chartered Institute of Logistics & Transport Achievement of the Year 2007 Award.
- Increasing numbers of schools and students attending each year.
- 2008 has been endorsed by the NRMA with schools already reserving places.

**Striving for best practice**
- Collaboration with both government and non-government organisations
- Interest has been generated both nationally and internationally.
- Creation of a formal plan to be available for distribution to other health services, states and countries.

**Innovation**
- The only formal road safety program developed that incorporates all emergency services as well as numerous health care providers and non-government organisations.
- Enables all students in NSW High Schools to access current information in:
  - Prehospital care
  - Trauma care
  - Rehabilitation
  - Expertise on car and tyre safety, safe stopping distances and car safety features.
Category

Health Care Performance Indicators
WINNER

Pre-hospital Acute Stroke Triage: Translating evidence into practice by improving patient access to acute stroke care.
Department of Neurology, JHH, HNEHealth in collaboration with Ambulance Service of NSW

Authors

Abstract
In acute ischaemic stroke, rapid access to organised stroke care and the delivery of ‘clot busting’ therapy (thrombolysis or tPA) results in substantial improvements in long-term outcome. The net benefit of tPA is a reduction in dependency and a reduction in the direct and indirect costs of stroke care, making it a highly cost-effective therapy.

Historically at both John Hunter Hospital (JHH) and other hospitals across Australia, the proportion of eligible acute ischaemic stroke patients treated with t-PA is less than 1%. Of those who actually arrive within the 3 hour eligibility time window, only 10% of these patients are treated.(LEVI, 2006) International experience suggests, however, that experienced stroke centres with well-organised local systems, can achieve tPA treatment rates of up to 20% (Grotta et al., 2001) of ALL patients presenting with stroke.

The Pre-Hospital Acute Stroke Triage (PAST) protocol was developed as a quality improvement initiative to:
1. Reduce pre-hospital and Emergency Department delays for stroke patients accessing stroke care, and
2. Improve access for acute stroke patients to thrombolytic therapy.

The JHH Acute Stroke Team in collaboration with the JHH Emergency Department and the NSW Ambulance implemented the following interventions:

1. A pre-hospital stroke assessment kit,
2. An ambulance hospital by-pass protocol for thrombolysis eligible cases,
3. A rapid deployment stroke team assessment.

Results
The PAST protocol was validated as an effective tool that can be used to determine the appropriateness of which patients should be taken directly to a centre that is capable of giving acute therapies. There was a modest increase in the number of patients being transferred to JHH (two per week), however, there was a decrease in transit time within the emergency department. The number of patients who received acute therapies was effectively tripled.

Introduction
Stroke is the leading cause of long-term adult disability and the third leading cause of death nationally. (Foundation, 2006) The majority of acute strokes are ischaemic, caused by blockage of a major brain artery. The chances of a favourable recovery from an acute ischaemic stroke increase substantially if patients gain timely access to organised expert stroke care including rapid
administration of clot dissolving (thrombolytic, tPA) therapy. The John Hunter Hospital (JHH) receives approximately 400 - 450 acute stroke patients each year, and the Hunter Region approximately 1000. Mirroring current national experience, in 2005, a meagre 23 (2.3%) of patients with ischaemic stroke in the Hunter Region received thrombolytic therapy (LEVI, 2006). In highly organised health system environments internationally, tPA therapy rates of up to 20% of all strokes have been reported (Grotta et al., 2001)

With expert assessment and selection of stroke patients presenting within 3 hours of onset, the use of intravenous tPA results in a 30% greater odds of recovery to full independence (Kwiatkowski et al., 1999).

Aims
Our aims were:
1. To reduce ‘pre-hospital’ delays to treatment; and
2. To streamline the acute receiving of patients by the existing acute stroke management team.

Method
We quantified this observation from our acute stroke therapy dataset/TASC, where over the course of 2005 less than 3% of acute stroke patients presenting to the JHH received tPA therapy. We then:
1. Conducted a review of the stroke clinical management summaries in the JHH TASC database,
2. Conducted an audit of patient charts for 2005,
3. Surveyed clinicians managing stroke patients at regional hospitals and
4. Held focus groups with the acute stroke team, ED (Emergency Department) staff and ambulance officers with a view to extracting the detail of factors associated with therapy and non-therapy eligibility.

Specifically we focussed on potentially modifiable “systems factors” associated with acute therapy ineligibility. This review indicated the following factors as being the dominant potential impediments to timely access to thrombolysis –

1. Presentations to hospitals that do not currently have the capability of delivering tPA
2. Inter-hospital transfers from non-tPA capable hospitals
3. Ambulance officers not having a focus on the potential for delivery of tPA therapy
4. Delays in notification to the JHH acute stroke team.

In addition to our local observations, review of the literature indicated that active collaboration with the ambulance service is an important strategy in decreasing the time to presentation for patients with acute stroke (Nassisi et al., 2000, Harbison et al., 2003, Kidwell et al., 2000). Several studies have demonstrated that paramedics can identify acute stroke patients with acceptable accuracy. Application of the Los Angeles Pre-hospital Stroke Screen (LAPSS) by paramedics (Kidwell et al., 2000) demonstrated a sensitivity of 91% and specificity of 97%, in comparison to neurologist assessment, while the Face Arm Speech Test (FAST) test (Harbison et al., 2003, Bray et al., 2005) was shown to also have satisfactory diagnostic sensitivity.

Based on the data and feedback received, the following solutions were developed:

1. A Hunter pre-hospital stroke assessment tool for our local ambulance officers was developed in consultation with the JHH ED and NSW Ambulance Service.’ The Hunter pre-hospital screening instrument was adapted from the UK FAST to complement existing assessments used by NSW ambulance officers. The Glucose Arm Speech ‘GAS’ assessment contains three key elements: glucose measurement, arm and hand strength, and speech disturbance (see appendix 1). In addition, the identification of an accurate time of onset was required.
Ambulance officers underwent training in the use of the GAS tool by the acute stroke team staff and Ambulance education staff. In particular the importance of accurate identification of onset time was emphasised. Pocket cards (see appendix 2) outlining the GAS test, and including the mandatory criteria for stroke thrombolysis, were distributed to all Hunter Region ambulance officers. The tool was piloted with a twelve-week pilot program that was introduced in September 2005 during National Stroke week.

2. A pre-hospital notification system.
   a. The on-call stroke neurologist is contacted directly by group text message from the Ambulance Northern Operations Centre (NOC).
   b. The on-call stroke neurologist then contacts the Senior Operations Commanding Officer (SOCO) at the NOC and is relayed information from ambulance officers in the field.
   c. If the patient is outside of JHH catchment area, the Neurologist either accepts the patient, or denies permission to bypass.
   d. The Neurologist then mobilises acute stroke team to meet and assess patient in the JHH ambulance bay.

**Study Design**

A pre and post implementation design was used to assess the effectiveness of the pre-hospital assessment tool and the notification system.

The primary outcomes were:
1. Number of patients receiving tPA therapy;
2. Appropriateness of hospital bypass.
3. ED transit time – determine if the increased numbers of transfers resulted in “Bed Block” within the ED.

Comparison was made between consecutive acute strokes ED presentations over the 6 month period September 2005 to March 2006; and consecutive PAST protocol notifications between September 2006 to March 2007.

**Study Analysis**

1. Implementation of tPA therapy - univariate analysis of proportions of patients treated with tPA across the two time epochs.
2. The number of patients who transferred under the PAST protocol who DID NOT receive thrombolysis.
3. Process of care within the emergency department. – comparison of the following time-frames
   a. ED transit times
   b. Symptom onset to arrival time for patients within JHH catchment

Among the perceived risks of the intervention were
1) Stroke may not be identified reliably by paramedics,
2) Miscalculation of time of symptom onset (particularly in the case of sleep onset strokes) may lead to inappropriate JHH transfer
3) ED workload would be increased dramatically
4) JHH beds would fill up with stroke patients who might have been managed in a less acute facility.
A database was created to manage collection and reporting of all PAST data. Reports were distributed to all key stakeholders (ED, bed managers, nursing unit managers, service manager for the division of medicine, ambulance operations centre, neurology dept, and acute stroke team) identifying problems, concerns, successes, and outcomes of each PAST patient.

Outcomes
Our primary outcome measures for the project were –
1. Access to tPA therapy
2. Appropriateness of hospital bypass
3. Time point indicators in the process of care

In the 6 month intervention period 48 patients were delivered to the JHH ED via the PAST protocol and were potentially eligible for treatment. This compared to 53 patients presenting to the JHH ED within 12 hours from time of onset over the comparison period (control). In order to make the groups more homogenous we excluded from the analyses those patients presenting over 12 hours from symptom onset, since acute therapies are not offered past this period. The characteristics of the two patient groups are outlined in table 1.

We found no statistical difference between the gender, age range, final diagnosis, non-strokes, and the majority of stroke subtypes. We did find a statistical difference between the number of Total Anterior Circulation Infarcts (TACI) and Transient Ischaemic Attacks (TIA’s) which may have contributed to the higher level of patients treated with thrombolytic therapy in the PAST group.

The National Institute of Health Stroke Scale (NIHSS) is an internationally validated scale used by members of the stroke team to help quantify stroke severity. This scale is not used by ‘non-stroke’ staff and is therefore not recorded for patients who are not assessed by the stroke team. Comparison of the NIHSS in the two groups was therefore not possible.

Table 1. Patient Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>PAST</th>
<th>Control</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation &lt;12 hours from Symptom Onset</td>
<td>n = 48</td>
<td>n= 53</td>
<td></td>
</tr>
<tr>
<td>Male Gender</td>
<td>23 (48%)</td>
<td>24 (45%)</td>
<td>p ≤ 1</td>
</tr>
<tr>
<td>Age Range</td>
<td>39-90 years</td>
<td>37-91 years</td>
<td>p ≤ 1</td>
</tr>
<tr>
<td>NIHSS</td>
<td>2-27</td>
<td>Not determined</td>
<td></td>
</tr>
<tr>
<td>Non-stroke</td>
<td>5/48 (10.4%)</td>
<td>4/53 (7.5%)</td>
<td>p ≤ 1</td>
</tr>
<tr>
<td>Stroke</td>
<td>43/48 (89.6%)</td>
<td>49/53 (92%)</td>
<td>p ≤ 1</td>
</tr>
<tr>
<td>Subtypes: TACI</td>
<td>21/43 (49%)</td>
<td>9/49 (18%)</td>
<td>p ≤ 0.01</td>
</tr>
<tr>
<td>PACI</td>
<td>9/43 (21%)</td>
<td>13/49 (26.5%)</td>
<td>p ≤ 1</td>
</tr>
<tr>
<td>LACI</td>
<td>5/43 (11.6%)</td>
<td>8/49 (16.3%)</td>
<td>p ≤ 1</td>
</tr>
<tr>
<td>POCI</td>
<td>1/43 (2.3%)</td>
<td>0/49 (0%)</td>
<td>p ≤ 1</td>
</tr>
<tr>
<td>TIA</td>
<td>3/43 (7%)</td>
<td>15/49 (30%)</td>
<td>p ≤ 0.01</td>
</tr>
<tr>
<td>HAEM</td>
<td>4/43 (9%)</td>
<td>4/49 (8%)</td>
<td>p ≤ 1</td>
</tr>
</tbody>
</table>
Diagnosing Stroke in the Field
The differential diagnosis of stroke is not always straightforward for two reasons:
1. There are several subtypes of stroke and,
2. Some non-vascular disorders may have clinical pictures that appear identical to strokes.

In a cohort of 400 patients admitted with ‘stroke symptoms’ Libman (Libman et al., 1995) found that 19% of patients had a ‘non-stroke’ final diagnosis. The top four stroke mimics were unrecognised seizures with post ictal deficits, systemic infections, brain tumour and toxic metabolic disturbances. Of the five PAST patients with a final ‘non-stroke’ diagnosis, one had hypotension due to bacteraemia, one had a migraine, two had seizures and one patient had an episode of severe neurological deficit with no organic cause. In this study the ten percent false-positive diagnosis rate for ambulance officers was slightly less than Libman’s 19%.

The proportion of agreement between ambulance officers in the field and the neurologist was 90%. See figure 1. This compared favourably with the Los Angeles Prehospital Stroke Screen (LAPSS) [8] and the Face Arm and Speech Test (FAST) with sensitivities of 91%, and 79% respectively. [7]

Due to limited data it was not possible to accurately estimate the number of false-negative diagnoses, nor the specificity of the accuracy of diagnosis of stroke by ambulance officers.

Final Diagnosis of patients delivered to JHH ED via PAST protocol.

Figure 1 Final diagnosis of patients delivered to the ED via the PAST protocol. The sum of Ischaemic Strokes (IS), Haemorrhages (HAEM) and Transient Ischaemic Attacks (TIAs) = 90%, while non-strokes = 10%.

Time Point Indicators
1. Symptom Onset Time
The identification of an accurate symptom onset time is critical when determining whether a patient is eligible for thrombolytic therapy. Of the 43 patients admitted with stroke symptoms in the PAST group, time of onset was identified correctly by ambulance officers in 40 (93%) of instances. In three instances (7%) the time of symptom onset was incorrectly determined by ambulance officers. They determined the time the patient awoke from sleep as the time of stroke onset. A patient who
has symptoms upon waking is usually classified as a ‘sleep onset’ stroke and the time of symptom onset is taken from the last time the patient was seen well, or went to sleep.

2. Onset to Door
For patients with ischaemic stroke the average time from symptom onset to arrival at the ED (Onset to Door) was 2:19 hrs mins for PAST patients, and 3:39 hrs mins for controls (p=0.0026). Given that the demographic characteristics of the groups were similar it could be hypothesised that PAST patients were being triaged and transported by ambulance officers more rapidly.

3. ED Transit Time (TTW)
One of the major concerns of all stakeholders was the potential of the PAST protocol to dramatically increase the number of ED presentations, and increase the ED workloads. This was not the case. Our results showed that over the study period, 48 patients were delivered to the JHH ED via PAST, or a very manageable two extra patients per week.

An analysis of ED transit times (Door to Acute Stroke Unit or ward) showed the PAST group spending half as many hours in the ED as the control group with an average ED stay of 2:29 hrs/mins for the former, 6:08 hrs/mins for the latter. The difference between the two groups was statistically significant p <.0001. It should also be noted that during the patient’s brief stay in the ED the majority of the care is managed by the stroke team and the imaging department, leaving ED staff to care for other patients.

Our results have shown that ED transit times for PAST patients have been as short as 30 minutes with at least forty percent of patients receiving tPA (within the three hour treatment window) in the ASU. The delivery of acute therapy in a specialised stroke unit is better for the patient, the family, and nursing staff.

Further examination of the ischaemic stroke sub-group showed a significant statistical difference between the numbers receiving acute interventional therapy in the PAST group 23 (64%), and the Control group 6 (20%) (p ≤ 0.001). (See figure 3).
23/36 patients in the PAST group with ischaemic stroke, received acute interventional therapy compared with 6/30 in the control group. Thrombolytic therapy was withheld in 13 patients as inclusion criteria had not been met. Six (47%) patients not receiving tPA had symptoms that were too mild or resolving; three (23%) patients were ‘sleep onset’ strokes arriving outside of the treatment window; two (15%) patients were medically unsuitable due to an increased risk of bleeding and two (15%) patients had recanalised spontaneously (brain artery had re-opened) by the time CT scan attended. (see figure 4) In all 13 patients the risks of administering tPA outweighed the potential gains, therefore tPA was withheld.

Figure 4  13 patients in the PAST group were not eligible for thrombolytic therapy. 6/13 = symptoms too mild; 2/13=high risk of bleeding; 2/13= spontaneous recanalisation; 3/13 =Sleep Onset.

Patient Outcomes
The comparison of patient outcomes between recipients of tPA and non recipients of tPA was not considered reasonable because of the heterogeneity of stroke severity within the PAST group. Patients receiving treatment had greater NIHSS scores (8-27) and a poorer prognosis, while 47% of those not treated had lower NIHSS scores (0-5) and a better prognosis. PAST patient outcomes were thus compared with tPA- eligible control patients from a meta analysis of published tPA trials. [11] Compared with published trial data, PAST patients treated with tPA were more likely to be independent, (Modified Rankin score <2) at three months. The percentage of patients who
remained dependent at three months (Modified Rankin Score >2) after treatment was 10% less in the PAST group than in the comparison group. (see figure 5)

Figure 5: Patient 3 month outcomes based on MRs. PAST patients compared with published tPA trial meta analysis results.

Effective Leadership
The PAST project has benefited greatly from the vision and passion of lead members of the Acute Stroke Service. Headed by national and international champions for stroke, the PAST team has enjoyed strong direction, inspiration and success. Collaboration, contribution and a common desire for excellence have strengthened partnerships between NSW Ambulance, ED, Hunter Imaging, and the Acute Stroke Team. The result is a more integrated service that is providing improvements in equity of access of acute stroke patients across the Greater Newcastle Sector to best available acute stroke care.

As a direct consequence of PAST, the acute stroke patient’s journey from symptom onset through ambulance assessment, ED triage, stroke team assessment, CT, acute treatment and delivery to the Acute Stroke Unit is becoming more seamless. With the support of Bed managers, Nurse Unit Managers, Hunter Imaging and medical and nursing staff, we are now able to provide timely evidenced based interventional care for patients with acute stroke.

Best Practice
At the national level the prioritisation and preferential transport by Emergency Services of suspected stroke patients to centres with stroke units is in line with the recommendations of the National Strategic Improvement Framework for Heart, Stroke and Vascular Disease and is in keeping with the 2005 National Stroke Foundation (NSF) Guidelines.

At an Area level PAST has provided the perfect opportunity for clinicians, academics, and paramedics to work in partnership to provide a more efficient and integrated acute stroke care delivery model based on evidence based practice.

Continuous improvement
PAST is now an integral part of acute stroke care across the lower hunter. The collaborative approach of the JHH acute stroke team, NSW Ambulance and JHH ED and has encouraged effective partnerships resulting in a strong an integrated acute stroke service. Ongoing clear direction, communication, and the timely reporting of results have helped all parties maintain a focus on PAST. The success of PAST, reflected in reduced morbidity and mortality, reduced ED transit times and reduced access block, serves as a reminder to us all that we are making a huge difference to the patients and families affected by stroke. This same success continues to inspire the refinement of processes and systems in order to improve patient access to acute stroke care.
Future Scope
The PAST project can be adapted quite easily to any health service with acute stroke interventional therapy capability. PAST is currently being considered for roll out across other areas of NSW as a model for acute stroke services. The PAST project is an attractive solution that works within existing infrastructure, resources and systems. Through effective partnerships, collaboration and commitment PAST has had a positive impact on morbidity, and mortality and the development of a seamless model for care of the acute stroke patient.
Appendix 1

PRE HOSPITAL ACUTE STROKE TRIAGE: ASSESSMENT TOOL

TIME OF SYMPTOM ONSET MUST BE LESS THAN 2 HOURS

Patient Surname:  
Case No:  
Date:
Time of patient assessment :  
Time:
UNSURE
YES  NO

Time of onset of symptoms: _________ (less than 2 hours)

If the patient wakes with a deficit or cannot talk, then the time is taken from the last time the patient was seen without deficit.

Glucose:
Is the patient's BSL inside of the normal range 4mmol-17mmol
Recorded BSL _mmol/l @ _______ hours.

Arm:
Lift the patient’s arms both outstretched at 90° to trunk.
Ask the patient to hold them in that position for 5 seconds.
Does one arm drift down or fall rapidly?
Is handgrip weak on the same side?

Is the loss of power noted on the

Speech:
Attempt to have the patient say “You can't teach an old dog new tricks”.
Ask a relative or friend if speech appears normal
Ascertain if speech is slurred or patient has difficulty finding words.
Is there discernable new speech impairment?

CRITERIA FOR STROKE THROMBOLYSIS

✔ Must be YES to all of the above.
✔ The symptom onset time is definitely within 2 hours
✔ Symptoms not improving
✔ The patient is more than 18 years old
✔ The patient is normally ambulant Not previously wheelchair or bed bound
✔ The patient has no history of seizures/epilepsy

If the patient meets the criteria for thrombolysis, follow the Stroke Intervention Protocol.

It is vital that every attempt is made to have a relative attend the hospital with the patient unless this will cause a delay in transport.

Reference List
Submissions Health Care Performance Indicators

Clinical Indicators
Kerala Institute of Medical Sciences, Trivandrum, Kerala, India

Author(s)
Infection Control - Nosocomial Infection Cases
Ms Aysha Mubarak  Infection Control Nurse

Laboratory Services - Sample Rejection
Dr Jayasree Kulkarni  Coordinator – Laboratory Services
Mr Austinlal M Jose  Quality In charge – Lab

Aim
To monitor the processes and improve the quality of service.

Abstract
Performance indicators help to measure the performance quantitatively. Indicators are very useful in improving clinical services and reducing adverse clinical incidents. The indicators help the department to identify the problematic area or the area where they have to improve. All the departments take the statistics of performance indicators and analyze them on a monthly basis. These indicators can be used to start a quality project. These are the baseline data collected to improve quality of healthcare services. There are hospital wide clinical indicators (e.g.: Nosocomial infections – Infection control). In this report clinical indicators from the following departments are discussed.

• Infection Control - Nosocomial Infection Cases
  This indicator shows the various types of nosocomial cases occur in the hospital. Through monitoring the nosocomial infections the trend of the infections can be analyzed and necessary steps can be taken to reduce the infections. The common infections in the hospital are Surgical Site Infections and Blood stream infections. Nosocomial infections were high in April 07 (5). But by strengthening preventive measures we could reduce the number in May 07 (3).

• Laboratory Services - Sample Rejection
  This indicator regards with the total rejected samples received by lab from other areas (clinical) of the hospital. It analyses the reason behind sample rejection and helps to find the area from which the number of rejected samples are maximum. Total number of rejected samples was high in March 07 (131). Through proper training we could reduce the number of rejected samples to 90 in April 07.

1. INFECTION CONTROL - NOSOCOMIAL INFECTIONS

   Definition
   This indicator shows the various types of nosocomial cases occur in the hospital in a month.

   Rationale Of The Indicator:
   • To improve patient care.
   • To monitor nosocomial infection
   • To reduce further occurrence of infections in the hospital.

   Methodology
   Source of data: Nosocomial Report

   Numerator
   Total number of reported cases of different types of nosocomial cases (Surgical Site Infection, Blood Stream Infection & Urinary Tract Infection.) per month.

   Denominator
Total number of reported Nosocomial Infection Cases per month.

Baseline Data
- Total number of nosocomial infections is highest in April 07 – 5 nos.
- The infection shows an increasing trend in March 07 & April 07.
- Surgical Site infection contributes maximum to the nosocomial infections.

Action Plan
- Continue monitoring
- Special focus on SSI and find the reasons for increasing SSI

Outcome
The number of nosocomial infections found to reduce in May 07 – 3 nos. compared to April 07.

2. LABORATORY SERVICES - SAMPLE REJECTION

Definition
This indicator regards with the total rejected samples received by lab from other departments of the hospital.

Rationale of The Indicator:
- To identify the department from which maximum rejected samples received.
- To find out maximum number of rejected samples received from each department per month.

Baseline Data
Number of samples rejected found to be increased in March 07 (131).

Action Plan
Department wise statistics on rejected samples was taken to find the area from which the number of rejected samples is maximum.

Reasons for sample rejection
Number of lysed samples is more than that of clotted and other reasons.

Actions taken
- Encouraged the use of vacutainers to collect blood
- Training given to nursing staff on how to use vacutainers

Outcome
- The major reason for the rejection was sample lysing.
- It found reduced in April 07 (99) after the corrective measures.

Application of EQuIP Principles

Consumer focus
Early treatment initiation.

Effective leadership
Responsibility.

Continuous improvement
Continuous monitoring.

Outcomes
- Early initiation of treatment.
- Reduction in nosocomial infections.

Striving for best practice
Comparing the statistics on nosocomial infections with the national and international average.

Applicability to Other Settings
- Helped to improve nursing care due to improvement in infection control measures.
- Improved surgeon’s satisfaction because of getting pathology report early.
Clinical Indicators in General Medicine
Southern Health, Quality Unit, Clayton South, VIC

Author(s)
Tonina Hore  Quality Coordinator, Medicine Program, Southern Health
Richard King  Medical Director, Medicine Program, Southern Health
Don Campbell  Unit Head, General Medicine, Monash Medical Centre, Clayton.

Aim
Enhance patient care through the implementation of a suite of clinical indicators into the general medical units of Southern Health.

Abstract
The Medicine Program at Southern Health has taken the established clinical indicators program developed at Melbourne Health, through collaboration undertaken with the Division of General Medicine and the Clinical Epidemiology and Health Services Evaluation Unit, and adapted it so it can be implemented into the General Medicine Program across multiple sites within Southern Health.

The methodology used for the original program was resource intensive; an alternative method of data collection was required to enable the program to be adapted. The revised audit tool has reduced data collection time by up to 80 per cent. The revised audit tool also has the benefit of improving compliance by acting as all medical staff have to enter the data on patient discharge, moving data collection from a retrospective to a prospective data entry model.

Following an implementation trial at the Casey Hospital, the clinical indicator program will be extended into the remaining general medical units at Dandenong Hospital and Monash Medical Centre, Clayton. Internal benchmarking within Southern Health will begin when the program is fully established.

The ultimate aim of the project is to extend the clinical indicator program and explore external benchmarking opportunities with other general medicine programs in the rural hospitals at West Gippsland and Latrobe Regional Hospitals, together with Melbourne Health.

Application of EQuIP Principles

Customer focus
Clinical indicators are aimed at ensuring all patients within general medicine are provided with a standard of care which is evidence-based best practice.

Effective leadership
• The effective implementation of this process has been enhanced with the full support of the Medical Director of the Medicine Program, who is the clinical champion in consultation with key stakeholders of the general medicine program including unit heads.
• Collaboration has been established between each of the participating hospitals.

Continuous improvement
• With general medical units based on three sites within Southern Health, evaluation includes internal benchmarking.
• The established collaboration will allow for external benchmarking with other health networks.
• Regular evaluation of the data will provide feedback for medical staff involved and a mechanism for recognising success and to identify opportunities for improvement.
The process allows for ongoing monitoring of indicator data; the process ensures that the data is analysed and acted upon to achieve improvements in care.

**Striving for best practice**
- The clinical indicators within the program have been chosen due to their level of evidence of Best Practice and their clinical importance as nominated by clinicians.
- The process enables care to be improved by ensuring patients receive optimum care in the following six areas: thromboprophylaxis, diabetic complications, cognitive assessment, osteoporosis, heart failure management and rehabilitation and chronic obstructive pulmonary disease rehabilitation.

**Innovation**
- The design of the audit tool has enabled the range of indicators to be increased without increasing the resources required for data collection.
- The development of a new data collection system has enabled data to be obtained prospectively, rather than relying on a resource-intensive retrospective model based on purpose sampling strategy for case note audit which is parsimonious.

**Applicability to Other Settings**
The method of data collection and the audit tool can be readily extended into many additional clinical settings. It is particularly applicable to monitoring and improving patient care in a clinical environment where resources are limited.

**Acknowledgments**
Melbourne Health – Caroline Brand and Carol Roberts.
Latrobe Regional Hospital – David Ogilvy and Anthony Boers.
West Gippsland Hospital – Bruce Maydom.
Embedding a Performance Culture in the Hornsby Ku-ring-gai Health Service (HKHS) Emergency Department (ED)
Hornsby Ku-ring-gai Health Service, Medicine, Emergency Department & ICU, Hornsby, NSW

Author
Ros Ferguson

Aim
To introduce a performance culture into the Emergency Department resulting in overall performance improvement.

Abstract

Method
In 2004 the Emergency Department (ED) at Hornsby Ku-ring-gai Hospital (HKH) was struggling to meet NSW Health performance targets. Working in partnership the ED and Hospital Executive introduced a number of initiatives to turn the performance of the department around:

- investing in the ED – a ‘whole of hospital’ approach
- providing strong and visible leadership – ED staff were empowered
- focussing on staff – nursing career paths were developed and staff encouraged to identify and contribute to changes
- embedding ongoing performance monitoring – activities instituted to manage and monitor the change projects have become part of everyday business.

Outcomes
Collectively these initiatives have resulted in a new model that uses fewer staff at a potential cost saving of around $438,000, a department that is motivated, vibrant and fully recruited and the ED is now amongst those leading the state in regards to reducing the length of time patients are waiting to be seen.

Application of EQuIP Principles

Customer focus
Established new patient routes – Fast Track and Triage and Treat - to speed up access to definitive care and improve patient outcomes

Effective leadership
Senior management at HKHS, realised the need to invest in improving the performance of the ED. The hospital: Invested in the improvement project; demonstrated the commitment of Senior Executive; and approached the project as a whole of hospital issue. This commitment set an example for other staff to follow and demonstrated a commitment to embedding a performance culture at HKHS.

Continuous improvement
- continued support and leadership from the HKHS Executive
- established Integrated Team Model of Care
- permanent implementation of staff roster changes and coverage
- permanent implementation of triage strategies including the Triage tool, “Triage and Treat” and “Fast track” models
- ongoing performance tracking established in ED.
Striving for best practice

- In 2004/2005 the ED was struggling to meet NSW Health performance targets. In Triage categories 4 & 5 HKHS results were consistently falling below the NSH benchmark levels of 70%.
- 2006/2007 the ED is achieving and exceeding all of the NSW Health Performance Targets including triage categories, off stretcher times and Emergency Access Performance.

Innovation

- Integrated Teaming model.
- Fast Track.
- Triage and Treat.
- Realigned activities with roles.

Applicability to Other Settings

- The project relates to the goals of NSW Health: Future Directions for Health in NSW- toward 20256. In particular, to manage health services well using finite resources wisely, delivering services efficiently and effectively and creating a sustainable system for the long term. The values address the provision of well coordinated care by members of an effective and supported team.
- This approach to clinical redesign can be easily adapted to other services. Presently at HKHS the lessons learned from this project are guiding a clinical redesign in surgery project.

NSW Department of Health 2007- Future Directions for Health in NSW- toward 2025.
General Medical Indicators Program (GMIP)
Melbourne Health, Clinical Epidemiology & Health Service Evaluation Unit (CEHSEU), Department of General Medicine, Parkville, VIC

Author(s)
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A Gorelik  Statistician
C Roberts  Project officer
A Prof D Russell  Director, Department of General Medicine

Aim
The GMIP was established to develop a set of clinical indicators against which GM clinicians could measure their performance in implementation of best practice into their everyday care and use these indicators to benchmark against future improvements internally and/or be benchmarked against similar organisations.

Abstract
The GMIP team was established to focus on inpatient care in which ‘process of care’ would be the measurement focus. GM physicians were asked to provide a list of priority areas where they perceived gaps in achieving evidence into practice. Existing national & international indicator sets were reviewed, the team brainstormed and a final indicator set was selected.

The selected indicators are:
- Venous thrombosis prophylaxis.
- Cognitive status and assessment.
- Congestive Heart Failure - use of ACE inhibitors, β blockers and referral to cardiac rehabilitation.
- Chronic Obstructive Airways Disease - referral to pulmonary rehabilitation.
- Diabetes Mellitus – annual lower limbs and ophthalmic assessment.
- Low trauma fracture management.
- Continuing care after discharge – provision of consumer care plans.

The project was implemented within the whole of General Medicine at RMH (Royal Melbourne Hospital) using a multifaceted evidence-based implementation strategy including academic detailing at grand rounds, orientation sessions for interns and registrars, display of posters & issue of pocket-sized reminder cards to wear with their nametag. During 2006, a more intensive implementation strategy involving weekly reminders and weekly self-audit of the indicators was undertaken within 2 units (of the 4 medical units) to assess the contribution of intensity of implementation to effectiveness of implementation.

Evaluation involved before (3 time points) and after (1 time point) medical record audits using a structured audit tool to ascertain rates of documentation and adherence to indicator guidelines. A structured clinician survey was undertaken in December 2006 & included questions that assessed senior and junior medical staff awareness of the program, use of, satisfaction with and perceived barriers to use of the clinical indicators and impact and burden on practice.

Application of EQuIP Principles

Consumer focus
The indicators were selected because they:
- reflected opportunities for improving patient care
- were focused on inpatient care processes
• could be incorporated easily into usual care
• have an important relationship to better health outcomes.

*Effective leadership* by the GM physicians
• a pivotal component of implementation success.
• demonstrated in:
  o development of the indicator set
  o design of the implementation strategy
  o review and ongoing refinement of the program
  o disseminating information to colleagues at orientation sessions, peer review meetings, grand rounds, audit & feedback meetings.

*Continuous improvement*
• Developing unit policies and processes for monitoring and reporting clinical indicator rates that integrate with MH quality & safety framework.
• Long term governance process for GMIP review & refreshment (updating evidence and identification of new indicators).
• Standardised documentation tools will be implemented into medical records.
• Regular reporting processes will be integrated into divisional safety & service improvement reporting.
• Medical units will take over ongoing ownership for the clinical indicator set planning and monitoring in conjunction with the divisional safety and service committee.

*Outcomes*
• Improvement over time in documentation of recommendations in most indicators.
• Current documentation of care processes remains below target.
• There was no clear benefit of the high intensity implementation strategy (although numbers in each group were small and therefore confidence intervals were wide).
• Clinician survey outcomes:
  o overall response rate was 51.7%
  o awareness of the project was 75.3%
  o utility of the indicators was assessed at 64.3%
  o 50.7% of senior and junior medical staff reported change in practice.

*Striving for best practice*
GM clinicians:
• continue to be involved at every level of the project
• are keen to continue to measure their performance and benchmark against other organisations.

*Innovation*
Development of:
• a proforma medical admission template
• a discharge indicator checklist (in collaboration with Southern Health)
• a consumer discharge plan template.

*Applicability to Other Settings*
• The GMIS had been supported by the RMH medical advisory committee and Director of Clinical Governance.
• The indicator set has been adopted by National consultant physician groups (the RACP and the Internal Medicine Society).
• The program is also being implemented at other Victorian hospitals.
Indigenous Cardiac Outreach Program
The Prince Charles Hospital, Cardiology Unit, Chermside, QLD

Author(s)
Mr Rohan Corpus  Program Coordinator (Program Author)
Mr David Tibby  Clinical Advisor (Program Author)

Aim
Provide culturally appropriate cardiac intervention to improve Indigenous cardiac health.

Abstract
The project began by:
- Initiating links with the Indigenous communities involved speaking honestly, openly and clearly defining the expectations on both parties and establishing a bilateral partnership:
  o Which involved extensive negotiations at community meetings to reassure the community that this model would be sensitive, respectful and sustainable?
  o The major aspect in this dialogue was to clearly demonstrate to the community that they had complete control around the acceptance or rejection of the Cardiac Outreach Program.
- Concurrently the District Health structure was contacted to begin discussions about the philosophy behind the project aims.
- Coordination of specific cardiac education was delivered through an Adult Learning Model, with a specific ‘barefoot doctor approach’ in the teaching of the cardiac information and the assessments tools that accompanied the skill set.
- The Team flies into community sites and provides cardiac outreach clinics in Community Health Centres. The Health Care Workers in collaboration with the Cardiac Outreach Team and local health service coordinate the clinics.
- Prior to the cardiac clinics the Indigenous Health Care workers engage the community through the completion of a pre-screen cardiac risk assessment tool, and refer these individuals to the next clinic.

Application of EQuIP Principles

Outcomes
The following outcomes are measured by response and survey and the communities have been vocal in their praise and satisfaction of the service at all sites, evidenced by the clinic presentation figures:
- community engagement in the clinics
- raised community awareness of individual cardiac risk factors
- enhanced cardiac knowledge & assessment skills for health care workers
- changes in individual lifestyle behaviours
- improved dietary intake
- community satisfaction & improved confidence in Queensland Health services
- satisfaction with the cardiac outreach service.

Social Outcomes
Through creative programming the cardiac outreach program has enabled a marriage of two worlds, traditional health and contemporary medicine that is delivered within the culture. The net result of this harmony has seen an improvement in staff enthusiasm, commitment and responsibility. Furthermore, the cardiac team have encouraged innovative program responses and local health care workers confidence and leadership skills. Armed with pride, compassion and knowledge health workers are examining and educating patients about their health and more specific contributing cardiac risk factors. This framework has allowed the health care workers and the community to deal with cardiac health in an integrated and culturally appropriate way.
Consumer focus
A key in our program framework is the relational engagement between the horizontal (bottom-up) and vertical (top-down) lines of communication. It has been a priority for the cardiac outreach program to establish equitable relationships with Indigenous communities that is built on dialogue and capacity enhancement.

Effective leadership
Leadership is a shared responsibility between the community, the health care workers and the cardiac outreach program team. The cardiac outreach program themes complement traditional Indigenous authorities that prioritise community governance and leadership. To maintain cultural practice the cardiac outreach program enables community, in collaboration to coordinate their health services.

Striving for best practice
The authors believe that the development of this framework and the implementation of this model reflect best practice for community participation, community ownership and responsibility, reflected against international community development frameworks. The Cardiac specific interventions are delivered by cardiac specialists in accordance with international cardiology benchmarks.

Innovation & Continuous Improvement
We would like to incorporate continuous improvement principles for the Indigenous health care workers by:
- establishment of a cardiac network for the health care workers
- program exchanges from one district to another
- facilitate a cardiac health conference for health care workers
- production of audio visual teaching / learning materials
- The Minister for Health announced this program as an innovation for Queensland.

Applicability to Other Settings
This framework has attracted the attention of the Queensland Dental Service, Population Health Team, North Queensland Cardiac Rehabilitation and the Chronic Disease Team-Queensland Health because it has been recognised as a valuable approach to foster community buy in and the community development model can be the underpinning platform for other medical services in order to develop sustainability.
Performance Indicators
Kerala Institute of Medical Sciences, Trivandrum, Kerala, India

Author(s)
Radiology - Reasons for Wastage of X-Ray films
Ms Raheena Beegam - In Charge Radiology

Bio Medical Engineering - Analysis of Department Wise Break Down Calls
Mr Abhilash S - Bio Medical Engineer

Aim
To monitor and improve processes.

Abstract
Performance indicators help to measure the performance quantitatively. Each department can have performance indicators, which are related to their process. The indicators help in identifying and surveillance of core department activities and to identify the problematic area or the area where they have to improve. The indicators can be used to identify the volume of work in a department (e.g.: Number of outpatients/month – Department of Guest & Public Relations). All the departments take the statistics of performance indicators and analyze them on a monthly basis. These indicators will also help us in identifying a quality project. There are hospital wide Performance indicators (e.g.: Number of Patients from different places – Marketing Department). In this report 2 performance indicators from the following departments are discussed.

- Radiology - Reasons for Wastage of X-Ray films.
- Bio Medical Engineering - Analysis of Department Wise Break Down Calls.

These indicators helped the departments to improve their performance. Through staff training and analyzing the statistics all the department could benefit from their performance indicators. The major reason for X-ray film wastage was staff related issues like carelessness and improper handling of machines. Through training it got reduced from 50 numbers in April 07 to 15 in May 07. Analysis of breakdown calls to Biomedical department helped the department to identify the area where maximum breakdown occurs and the equipments for which the problem occurs. Maximum number of complaints was from Medical Intensive Care Unit and wards. The equipments for which break down happens were bedside monitors and ventilators. Bio medical Department conducted training for the staff and the complaints from Medical Intensive Care Unit and wards reduced.

1. RADIOLOGY - REASONS FOR WASTAGE OF X-RAY FILMS

Definition
This indicator analyses the number of x ray films wasted per month and the reasons behind that.

Rationale of the Indicator
- To find the main reason behind the wastage.
- To find out the number of films wasted.

Objective
- To reduce the wastage and improve the quality.

BASELINE DATA
- Total number of films wasted in October is 86.
- The factor, which contributes maximum to the wastage of X-Ray films, is staff related reasons. It contributes 58% to the total wastage.
- Machine related problem contributes 14%.
- Position of the patient contributes 23%.
- Patient related is only 5%.
ACTION PLAN
Give awareness to the staff, as the major reason for the wastage of films is less staff awareness.

OUTCOME
- Through various staff awareness programs the wastage of films due to staff related issues reduced from 50 (April 07) to 15 (May 07).
- Even though the number of films wasted by staff related problems, are reduced the wastage of films by patient related problems increased. This may be due to the fact that the number of examinations in May 2007 (7406) is higher than that of April 07 (6730).

2. ANALYSIS OF DEPARTMENT WISE BREAK DOWN CALLS – DEPARTMENT OF BIO MEDICAL ENGINEERING

Definition
The number of calls related to the breakdown of a machine received in Bio medical department per month from other departments in the hospital.

Rationale Of The Indicator:
- To find out the average complaints per staff in each shift.
- To find out number of calls received from each department per month.
- To identify the department from which maximum calls are received.
- To identify unwanted calls.

Numerator
Total number of breakdown calls to Bio medical Engineering department from different departments.

Denominator
Total number of breakdown calls to Bio Medical Engineering Department per month.

BASELINE DATA
- Maximum calls are received from MICU & Wards in the month of May.
- Number of calls has been reduced from ICCU, MICU and dialysis in the month of May compared to last month.

ACTION PLAN
- Identify the machines in MICU & Wards for which more calls are getting and train the staff to use the machine.
- Critical calls and unwanted calls should be identified and necessary actions should be taken to reduce unwanted calls.

OUTCOME
The number of complaints from MICU and wards reduced.
Application of EQuIP Principles

**Consumer focus**
- Repeated X-rays, which may cause difficulty for patients, reduced.
- Proper handling of equipment. Thus equipment failure reduced.

**Effective leadership**
Training.

**Continuous improvement**
Continuous monitoring.

**Striving for best practice**
Computerized Radiography.

**Outcomes**
- Reduction in X-Ray film wastage.
- Reduction in calls regarding breakdown of equipments.

**Applicability to Other Settings**
Nursing staff became aware on how to use equipments for treatment.
Risk Matters – Cultural change facilitates successful development and implementation of a risk management system in a private health care organisation
St John of God Health Services, Burwood, NSW

Author(s)
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Aim
To develop an evidenced-based risk management program, which galvanises the participation of staff and minimises the risk exposure of the organisation.

Abstract
This submission focuses on the development of an organisation wide approach to risk management which has resulted in significant improvements in the safety of patients, staff and contractors who visit and work in the Service.

The submission shows the positive impact of cultural change on risk management in the organisation from a culture of blame to one of high support and participation; It demonstrates the major developments in structures and processes which have been implemented to support risk management, and the Key Performance Indicators (KPI’s) which were developed to measure the effectiveness of the program. Several of these KPIs are now benchmarked externally.

Application of EQuIP Principles

Customer focus
• Staff involvement in design of system and staff training;
• Focus on clinical risk - clinical risk assessment system and procedures in place at pre / admission and during admission.
• Focus on contractor management to minimise risk

Effective leadership
• Driven, facilitated and resourced by senior management
• Ensuring risk is a central issue / theme on key hospital committees
• Ease of access to leadership team – provision of staff forums with CEO, has enhanced change in organisational culture.

Continuous improvement
• Leadership commissioned the risk management working party, now a peak hospital committee, to facilitate and drive the development and implementation process.
• Review of external risk management resources to assist in learning
• Establishment and refining of various structures and processes to support risk management, following review and feedback from key stakeholders – inclusive of development of risk register; risk management policy; an integrated risk, hazard and incident report form; review of risk manager role in organisation; development of various communication and training tools and methods for staff; development of risk identification and safe work procedure templates;
• Development and use of KPI’s to monitor risk management at both governance levels and clinical and non clinical risks.
Striving for best practice
- Benchmarking partners use SJOGHS as a resource for risk management systems
- NSW Health referred another organisation to SJOGHS for assistance with risk management
- Well within the ACHS aggregate benchmark for rates of aggression/assaults and self-harm
- Within benchmarking partners results for falls / 1000 bed days; medication errors; self-harm;

Innovation
Many aspects of the risk management program are innovations from within the service. These include:
- The risk register
- The combined risk, incident and hazard identification and reporting tool
- Disaster management forums
- Risk and safe operating templates
- Self-directed learning tools
- Risk management “tours” to locate and learn how to report incidents and risks
- Listabed – documentation tools
- Clinical documentation forums

Applicability to Other Settings
Many aspects of the risk management program could be used and modified by other settings, inclusive of the training modules, risk register, risk management policy, the integrated risk and incident reporting form; disaster management forums; KPI’s.
The use of Clinical Indicators to Monitor and Improve the Quality and Safety of Care
Southern Health, Quality Unit, Clayton South, VIC

Author(s)
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Dr Bill Shearer
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Aim
The aim of this project was to improve clinical governance mechanisms across a large metropolitan health service by implementing a comprehensive suite of clinical indicators that are monitored at hospital, clinical program, unit and individual patient level.

Abstract
As part of a wide ranging review of clinical governance, the Monash Institute for Health Services Research was commissioned to review the current international literature and practice in relation to the use of hospital-wide clinical indicators as a measure of patient safety.

Recommendations from the review identified the most effective indicators for measuring patient safety which could be easily adapted to the Australian context. It also recommended that the organisation implement a Process Control Reporting Tool and develop stop and review rules.

Following agreement on the set of indicators to collect, the clinical coding department were asked to identify the appropriate complication codes for capturing each of the indicators. Expertise from the organisation’s Clinical Information Management Team was then used to access the mainstream patient administrative databases and develop reporting formats.

Different cuts of the data were made available including organisational, hospital, clinical program, and unit and ward perspectives. Initial testing of the definitions led to considerable amendments to the complication codes used and this refinement process is expected to continue. The indicators list itself has changed slightly and additional indicators are expected to be incorporated over time.

Fourteen performance indicators drawn from three separate patient information databases are now in place across the organisation. Each month the data is automatically refreshed and presented at the relevant clinical governance committee. Results are presented in control charts and colour coding is used to highlight unexpected variances. Where results fall outside the control limits an investigation and review process is triggered. A summary of the actual cases including the UR number is then sent to the relevant area for detailed review.

Application of EQuIP Principles

Consumer focus
- There has been growing public concern about hospital safety, which in the most part has been driven by publicity of cases where patient safety issues went undetected for long periods. This
The initiative aims to provide an indication of the safety of patients under the care of Southern Health.

- The starting point is the review of aggregate data and the end point is a detailed case review of a patient’s care management.

**Effective leadership**

- The Clinical Indicator Program runs throughout the organisation from the most Senior Committee (Board Quality Committee) to the Executive Patient Safety and Quality Committee, comprising all site directors, and the Joint Program Quality and Safety Committee which includes all program directors.
- The use of clinical indicators as a mechanism for monitoring patient safety has now been extended to include the establishment of program specific indicators.

**Continuous improvement**

- Initial testing of the definitions led to considerable amendments to the complication codes used and this refinement process is likely to continue.
- The indicators list itself has changed slightly and additional indicators are expected to be incorporated.
- Work to enhance the accuracy and meaningfulness of the data continues.

**Outcomes**

Practice improvement is a complex process that requires multi-faceted strategies and we do not expect that the monitoring of indicators alone is sufficient to shift practice. However, in combination with other initiatives the following outcomes have been achieved to date:

- Reduction in falls from an average of 2.97 in 2005-06, to an average of 2.85 in 2006-07.
- Reduction in cardiac arrests across the organisation.
- Investigation of transfers to a higher level facility.

**Striving for best practice**

- A comprehensive search of world wide literature form 1995-2006 was undertaken, with a primary focus on measurement of patient safety using clinical indicators.
- Online data bases including OVID, Medline, CINAHL and the Cochrane Library were utilised as well as the internet to ensure that non-peer reviewed were included.
- The hospital wide indicators were identified using best available evidence.

**Innovation**

This represents the first collaborative project between Southern Health’s Quality Unit, its affiliated Health Services Research Stream and the Clinical Information Management experts within the organisation. The synergy which this has created has resulted in a significant step forward in clinical governance.

**Applicability to Other Settings**

The definitions developed for each of the indicators as well as the processes established to extract and present the data should be able to be replicated within other acute hospital settings.
Using a PDSA Cycle to Improve Patient Health
Department of Corrective Services - Health Services, Greenough Regional Prison Health Centre, Geraldton, WA

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Aim
To use a Plan, Do, Study, Act cycle to improve the screening and management of diabetes, sexually transmitted infections and blood borne viruses within the prison population at Greenough Regional Prison.

Abstract
The audits were cross-sectional, carried out on the notes of all inmates at the regional prison over four weeks, in April 2004 and May 2006. Paper and electronic records were examined.

A standardised data collection sheet was developed and piloted. Data were collected, on drug use, screening for sexually transmitted infections and blood borne viruses, medications, vaccinations, prevalence of chronic disease and its management.

Application of EQuIP Principles

Customer focus
- The process and results of these ongoing audits have a direct value to both the patients and Department of Correctional Services Health Services.
- Prisoners are a captive audience and have "time" on their hands.
- Prison provides a stable environment to address health issues.
- Over the past two years prisoners have started to engage actively in their health with five prisoners giving up smoking.
- Ongoing audits provide the evidence and incentive for both the Department and prisoners to continue to invest in their health.

Effective leadership
- Greenough Regional Prison health service is leading the way in both the delivery and evaluation of its health care.
- Health staff have embraced the audits and have acted to respond to gaps in service after each report was presented.

Continuous improvement
- This documents an ongoing cycle of Plan Do Study Act.
- The audit in 2004 identified the need for more medical input as well as better screening of sexually transmitted diseases, blood borne viruses and lipids in patients with ischemic heart disease.
- The audit in 2006 demonstrated improvement in these areas and highlighted new areas for improvement.
- The introduction of diabetes care plans in 2006 and an electronic health record in 2007 will impact on outcomes in the future.
Other pressures such as prison overcrowding and pandemics will impact negatively on health care provision.
Developing a culture of reflection and action is critical to adequately responding to such threats and opportunities.

Outcomes
- Levels of screening have improved since 2004.
- Recording of temperature and height is poor and needs addressing as does the documentation of life style factors.
- In 2006 screening rates for diabetes were comparable to those found in the community and occurred within the recommended Royal Australian College of General Practitioners timeframe in 70-74% of cases.
- Only 24% reached Royal Australian College of General Practitioners targets of HbA1c <7.0.

Striving for best practice
- The audits use quality of care and clinical outcome targets derived from Royal Australian College of General Practitioners guidelines.
- The complete 2006 report compares results at Greenough Regional Prison with published evidence in Australia and two local diabetes audits.

Innovation
- Western Australia has the highest proportion of Aboriginal prisoners incarcerated and until now audits within the Australian prison system have been largely based in NSW where Aboriginal prisoners account for a small proportion of the prison population.
- Greenough Regional Prison has a higher proportion of Indigenous prisoners than most other prisons in Western Australia, with over 86%, compared to 40% in the overall WA prison population.
- Good prison health makes both ethical and financial sense.

Application to Other Settings
- This audit is suitable for other corrective service institutions.
- It is modelled on similar audits carried out in rural general practice In the Midwest Western Australia.
Student Awards

University of Newcastle
Background
The Faculty of Health, University of Newcastle requires the Bachelor of Medicine students to study patient safety and quality in health care. Students are required to carry out a quality project in the hospital in which they do their nine-week rotation in surgery and the emergency department. The aim is to identify patient safety issues and apply the quality tools to determine the causes and make recommendations to reduce the chance of the event occurring again. The Australian Council on Healthcare Standards supports the safety initiative by providing an award for the best project.

The following criteria were used to determine the best project
- an important problem was identified;
- appropriate tools were used to analyse the problem;
- a recommended intervention was established;
- the outcome of the intervention was measured.

The selection panel nominated a winning project and three honourable mentions.

The winning project:

Pre-transfusion requests: the (legally binding) pathology form
Burgess L, Williams M, Zawada KA

Background
During our ED rotation, we identified a recurring problem: filling out the pre-transfusion request forms and the correct labelling of the sample tubes

Aim
Develop a strategy to increase compliance with the guidelines for completing the forms

Methods
We reviewed existing strategies to ensure forms were completed correctly. An audit of the number of incorrect pre-transfusion request forms was carried out. We used a flow chart of the process and an Ishikawa diagram to identify possible causes and a Pareto diagram to present the results from the audit.

Results
The Pathology Service receives 50 – 60 requests a day and 5% were rejected. From the 63 rejections 81 errors were identified: discrepancy between time of collection on form and specimen tube (27%); patient details did not match on form and tube (21%); incompletely filled out by witness (16%) and collector (15%).

Implementation Plan
Results were discussed with staff and we received feedback for our suggested changes, which included: an education session; a handout on the errors and how to reduce them; a new pre-transfusion form. The latter would take time as old forms are still being used.
Recommendation
The Health service should continue to work on this, noting that past attempts have not solved the problem. A solution will require significant time and costs to implement.

Honourable mentions were awarded to:

A missed developmental dysplasia of hips: RCA
Murray PR, Shaw RS

Where are the Keys?
Clay-Williams DN, Gay LM, Peter-Przyborowska BA

Supracondylar fractures: a RCA
Gasemotse M, Har JT, Waliuddin AR

Projects submitted:

How vital are vital observations? The recording of vital signs at triage.
Considine RM, Mansour DJ, Myers RL, NG DF, Nkoane BA, Yim LY

Ectopic pregnancy – a near miss.
Chan MY, Gardner SJ, Greco LC

Peri-operative venous thromboembolic prophylaxis
Martens-Nielsen J, Scott RJ

Sticks and stones may break my bones but the orthopods will never find me…
Brownlow AL, Choudhury F, Huynh W

Legibility of doctors’ handwriting in medical records
Convery RE, Lambert SA, Moore AN

Audit of abdominal X-rays at Belmont ED
Nicholas BG, Yarnold DJ

Delayed diagnosis of slipped capital femoral epiphysis: RCA
Broderick SL, Kavanaugh KM, Thornbury KL

Clean your stethoscope!
Bamra ADS, Bhandari R, Lee K HY

A missed developmental dysplasia of hips: RCA
Murray PR, Shaw RS

Dying to go to the toilet: RCA
Krause TL, Mollard SL, Roervok JO

Dress to impress: the necessity of having a dress code for doctors
Hammond F, Lee A, Rigney LA, Singh T, Williams KM

Hip dislocation as a complication of total hip replacement
Kenig M, Kiiru GW, Ralston KM, Retnasaba J, Vujanov EI
Narcotisation and respiratory depression: RCA
Davik P, Gatei EW, Keightley PC

Adverse event involving stone fragmentation
Isaacs SJ, Rayar S

An elderly gentleman presents to the ED with chronic constipation
Bewisher SM, Dorr TL, Lidster PL, Peck G

RCA for a case of candida septicaemia.
Mcleod MG, Sandberg AK