QUALITY INITIATIVES

Entries in the 19th Annual ACHS Quality Improvement Awards 2016
Quality Initiatives

*Entries in the 19th Annual ACHS Quality Improvement Awards 2016.*

Published by:

The Australian Council on Healthcare Standards (ACHS)
October 2016

© The Australian Council on Healthcare Standards 2016

This work is copyright. Apart from any use as permitted under the *Copyright Act 1968*, no part may be reproduced by any process without written permission from The Australian Council on Healthcare Standards (ACHS).

Requests and enquiries concerning reproduction and rights should be addressed to:

The Development Unit
The Australian Council on Healthcare Standards (ACHS)
5 Macarthur Street
Ultimo NSW 2007

Recommended citation:

Previous volumes in this series:
1st Edition 1998
2nd Edition 1999
3rd Edition 2000
5th Edition 2002
7th Edition 2004
8th Edition 2005
9th Edition 2006
10th Edition 2007
12th Edition 2009
13th Edition 2010
14th Edition 2011
15th Edition 2012
16th Edition 2013
17th Edition 2014
18th Edition 2015
# Table of Contents

Introduction ........................................................................................................................................................................... 2

Winner Submissions ................................................................................................................................................................. 3

Highly Commended Submissions ............................................................................................................................................. 4

Category: Clinical Excellence and Patient Safety .................................................................................................................. 5
  Winner .................................................................................................................................................................................. 5
  Highly Commended ............................................................................................................................................................ 11
  Table of Submissions ......................................................................................................................................................... 15

Category: Non-Clinical Service Delivery ............................................................................................................................... 18
  Winner .................................................................................................................................................................................. 18
  Highly Commended ............................................................................................................................................................ 29
  Table of Submissions ......................................................................................................................................................... 31

Category: Healthcare Measurement .......................................................................................................................................... 32
  Winner .................................................................................................................................................................................. 32
  Highly Commended ............................................................................................................................................................ 51
  Table of Submissions ......................................................................................................................................................... 53
Introduction

The ACHS Quality Improvement Awards

The annual ACHS Quality Improvement (QI) Awards were introduced in 1998 to acknowledge and encourage outstanding quality improvement activities, programs or strategies that have been implemented in healthcare organisations.

In 2016, the 19th Annual ACHS QI Awards were open to submissions from all domestic ACHS and international ACHSI member organisations following the ACHS NSQHS (National Safety and Quality Health Service) Standards Program, EQuIP5 (Evaluation and Quality Improvement Program), EQuIPNational, EQuIPNational Corporate Health Services, EQuIPNational Day Procedure Centres, and the ACHS Clinical Indicator Program.

This year 67% were submitted in the Clinical Excellence and Patient Safety category, 21% in the Non-Clinical Service Delivery category and 12% in the Healthcare Measurement category.

Judging was conducted externally with separate panels of three judges for each of the QI Awards categories:

- **Clinical Excellence and Patient Safety**: This category recognises innovation and demonstrated quality improvement in the delivery of safe, effective patient care.
- **Non-Clinical Service Delivery**: This category acknowledges a demonstrated outcome of improvement and innovation in patient and/or consumer services and organisation-wide practice including services provided by community and allied health organisations.
- **Healthcare Measurement**: This category recognises organisations that have measured an aspect of clinical management and/or outcome of care, taken appropriate action in response to that measurement, and demonstrated improved patient care and organisational performance upon further measurement. Healthcare measurement can include data collected from the ACHS Clinical Indicator program or other methods of monitoring patient care processes or outcomes. Both quantitative and qualitative data can be used, however this category must describe the initial measurement, the analysis of that measurement, the action(s) implemented, and the improved measurement(s).

Each judging panel consisted of an ACHS Councillor, an ACHS surveyor and a representative from an ACHS member organisation.

Submissions were required to meet specific criteria that were weighted equally:

- Judges assessed all eligible submissions on the five (5) ACHS principles of: consumer focus, effective leadership, continuous improvement, evidence of outcomes and best practice;
- Judges assessed additional criteria: improvement in patient safety and care, measured outcomes, applicability in other settings, innovation in patient care and/or processes and relevance to the QI Awards category;
- The submission MUST relate to a period of up to no more than two (2) years prior to the year of entry.
The 19th Annual ACHS QI Awards 2016

Winner Submissions

Clinical Excellence and Patient Safety

Bankstown-Lidcombe Hospital, NSW

Doctors, Pharmacists, Nurses, Administrative staff, Patients and Carers – the new multidisciplinary team

Lucy Nair, Karma Mekhail, Natalie Raffoul, Wendy Harmer

Full Submission page 5

Non-Clinical Service Delivery

Children’s Health Queensland Hospital and Health Service, QLD

Good Start Program, Child and Youth Community Health Service

Good Start to Life – Co-designing optimal maternal and infant nutrition resources for and by Maori and Pacific Islanders families living in Queensland

Sebastien Brignano, Lose Seiler, Kirstine Kira

Full Submission page 18

Healthcare Measurement

Osborne Park Hospital, WA

Ambulatory Service

Sustaining Improvement in the management of the Endoscopy Waitlist

Anne MacDonald, Clare Matthews, Michael Levitt, Hooi Ee, Dev Segarajasingam

Full Submission page 32

Each winning submission in the ACHS QI Awards receives a Certificate of Acknowledgement, a QI Awards trophy, and a cash prize provided by ACHS.

ACHS publishes submissions from all participating organisations to share and encourage exceptional quality improvement strategies amongst the ACHS member organisations.

The full version of this document will be published on the ACHS website (www.achs.org.au).
Highly Commended Submissions

Clinical Excellence and Patient Safety

The Royal Children’s Hospital, VIC
Complex Care Service
Simplifying Complex Care
Lisa Stephens, Nicki Mountford, Susan Gibb, Doug Bryan
Summary Abstract page 11

King Edward Memorial Hospital - Women and Newborn Health Service, WA
Department of Pharmacy, Department of Safety, Quality and Performance, Medication Safety Review Group, Department of Postgraduate Medical Education, Antimicrobial Stewardship
From reflective learning to action: Reducing medication-related problem with an innovative, interdisciplinary, site-specific, targeted education model
Stephanie Teoh, Tamara Lebedevs, Nabeelah Mukadam, Amy Fitzgerald, Caroline Kerr, Patrick Yapp, Michael Petrovski, Caroline Hussey
Summary Abstract page 13

Non-Clinical Service Delivery

St Vincents Public Hospital Sydney, NSW
Environmental Services Darlinghurst Campus, St Vincent’s Public Hospital level 9 Xavier South BMT ward, level 7 and 8 Xavier North and South.
St Vincents Hospital Sydney Clean, Reliable, Trustworthy, Proven, Sustained Excellence in Patient & Resident Care – The Environmental Cleaning Review & NSW Blood & Bone Marrow Transplant Cleaning Project
Rob Gordon, Emily Heininen, Joanna Uribe, Kirsten Bruchhauser, Kylie Naudi, Michelle Wilson, Giulietta Pontivivo, Brett Gardiner
Summary Abstract page 29

Healthcare Measurement

Prince of Wales Hospital, NSW
Emergency Department
ED Navigator: impact and evaluation of ED performance of an extended service model
Wayne Varndell, Elizabeth Ryan
Summary Abstract page 51
A. AIM

In an effort to empower patients and carers to contribute towards their own medication management and safety, a multidisciplinary clinical workforce team collaborated with the patients and carers of Bankstown-Lidcombe Hospital to implement the NSW Health Medication Management Plan (MMP).

This project aimed to enhance collaboration between patients, carers and the clinical workforce to increase medication safety and reduce adverse events as a result of inadvertent medication errors throughout every patient journey.

B. SUMMARY ABSTRACT

Hospital Executives, Nursing, Medical and Pharmacy representatives formed a working party with the primary aim of ensuring that 100% of patients receive a Best Possible Medication History (BPMH) documented on a Medication Management Plan (MMP). A policy mandating MMPs for every inpatient was developed outlining accountability and detailed instructions on how to complete a BPMH, confirmed with two sources. Intensive education of 1,200 staff members, resource folders and lanyard cards provided a ready reference to staff. MMP education was included in facility orientation, clinical handover and Patient Journey Boards. Multilingual paper based and electronic posters targeting patients and staff were rolled out across the hospital.

Frequent hospital-wide audits showed that within two months, 100% of patients had a MMP at the point of care (i.e. the bedside). Approximately 92% of MMPs included a BPMH and over 60% had their BPMH reconciled with their medication chart. A multidisciplinary approach was successfully adopted with 41% of MMPs initiated by Pharmacists, 38% by Medical Officers and the remaining 16% by Nurses. These results continue to be sustained as determined by monthly audits, with the most recent audit in April 2016 showing 100% of patients had a MMP and 88% of MMPs included a BPMH. Results demonstrate a positive effect on patient safety with a considerable reduction in the average number of medication errors from 1.8 errors per patient in October 2013 to 0.8 in April 2015.

Collaboration between the clinical workforce proved successful in implementing an effective process of medication reconciliation with reduced incidence in medication errors.

C. REPORT

APPLICATION OF ACHS PRINCIPLES

1. Consumer Focus

Collaboration between patients, carers and the clinical workforce of BLH was crucial to the successful implementation of NSW Health’s Medication Management Plan (MMP). Patients and carers formed the centre of the multidisciplinary team with Medical Officers, Pharmacists, Nurses and administrative staff working with them as a trusted source to ensure a BPMH was documented and accurate for every patient on every admission. Not only did this project focus on empowering patients and carers to contribute towards the management of their medications, it also aimed to enhance medication safety more broadly and reduce adverse events due to inadvertent medication errors which in turn would reduce re-admission rates related to medication errors.

2. Effective Leadership

This project was led by a working party that contained senior Executives including the General Manager, Director Medical & Clinical Services, Director Nursing & Midwifery Services, Director
Pharmacy and Quality & Risk Manager. There was a multidisciplinary approach to implementing this change and the ability to make such substantial changes in such a short period of time demonstrates how effective this multidisciplinary leadership approach was.

During the National Accreditation process, it was identified that not all patients admitted to Bankstown-Lidcombe Hospital had a BPMH documented. If a BPMH had been completed, it was not always readily available at the point of care or at the point of clinical handover. This meant that medication related adverse events were potentially higher than they should be. This was confirmed by an audit conducted in October 2013 which showed patients were being exposed to medication errors related to the absence of a BPMH. More than half of all patients were missing at least one of their medications (Figure 1) and approximately 81% of all medication errors had the potential to cause moderate or severe patient harm (Figure 2).

In December 2014, only 39% of BLH’s patients were having a BPMH documented during their admission – not even half of these being available at the point of care (i.e. the bedside). It was also identified that pharmacists were solely contributing to 83% of these BPMHs which demonstrated a lack of engagement and understanding from the clinical workforce. The value of a BPMH being available at the patient’s bedside in a hospital setting has been
well established (Lau et al., 2000, Jacobson, 2002). This was confirmed in Bankstown-Lidcombe Hospital when a hospital wide snapshot audit conducted in October 2013 showed that 271 medication errors were identified by utilising the MMP at the bedside and over half of these errors were rectified by medical officers within 48 hours (Sourial Mekhail et al., 2014).

4. Planning and Implementing Solutions
Bankstown-Lidcombe Hospital established a working party in November 2014 (including Executive, Nursing, Medical and Pharmacy representatives). To ensure that every patient received a BPMH, all disciplines were mandated to complete a MMP using at least two sources to document a medication history – one of which was strongly encouraged to be the patient and/or carer. In order to facilitate the hospital-wide rollout of the MMP, a policy was developed which provided instructions on how to complete MMPs and outlined the accountability for each section.

Further to this, intensive education sessions begun in December 2014. The first phase of education included an overview of the importance of medication safety and how the MMP contributed to reducing medication-related adverse events. The second phase was a practical demonstration on how to complete the MMP. In total, over 1200 staff members from BLH attended these sessions. An introduction to the MMP was also included as part

Figure 3: Location of medication histories identified during a hospital wide audit conducted in December 2014.

Figure 4: The percentage of patients at BLH with a MMP
of facility orientation for ALL new staff. This education campaign emphasised that medication reconciliation was the responsibility of the entire clinical workforce and highlighted the need to collaborate with patients and carers as sources of information.

In order to educate patients and carers regarding the purpose and value of the MMP, posters were developed and displayed across ward areas. Bedside information bulletins also included prompts for patients to work with their clinical team to ensure their medications were accurately documented. Posters were made available in English as well as the five most popular languages of the local area. The bulletins were also displayed electronically in the hospital foyer.

MMP resource folders (including a sample MMP, the policy and guides to completion) were designed and made accessible on every ward of Bankstown-Lidcombe Hospital to ensure readily available information for all staff. To assist clinical staff in filling out the MMP, a lanyard card detailing instructions was developed.

To ensure that a BPMH is available to patients, carers and clinicians at the point of clinical handover, a MMP column was included in all Bankstown-Lidcombe Hospital Patient Journey Boards (PJB) to facilitate discussion during daily
meetings. Further to this, nursing and medical handover checklists were updated to include MMPs.

5. Evidence of Outcomes
To monitor the outcomes of this project, monthly audits capturing a large sample size (30% of inpatients randomly selected from each ward) are conducted. The following Figures 4 –7 provide compiled results of the audits to date. Results demonstrate that all patients in BLH have their MMP available at the bedside with almost all of these having a completed BPMH (Figures 4 and 5).

Results also demonstrate active involvement from the multidisciplinary team with a shared responsibility for medication reconciliation across disciplines (Figure 6). The majority of patients (84%) have their BPMHs reconciled with their National Impatient Medication Chart (NIMC) (Figure 7) which ensures medication discrepancies are identified and a clear record of medication changes during admission is maintained. In attempts to quantify the effect of these interventions on patient safety, a follow up audit was conducted in April 2015.

Results show a vast improvement in medication errors at BLH (Figure 8) with a considerable reduction in the average number of medication errors per patient (Table 1).

Table 1: Average number of medication errors per patient.

<table>
<thead>
<tr>
<th>Date</th>
<th>Average medication errors per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2013</td>
<td>1.8</td>
</tr>
<tr>
<td>April 2015</td>
<td>0.8</td>
</tr>
</tbody>
</table>
6. **Continuous Improvement**
Monthly audits continue to be conducted and fed back across the hospital so that the sustainability of this project can be monitored. Practical education sessions continue to be offered every month to all clinical staff with patient-focused posters and information readily available. Ongoing education also continues to be provided during facility orientation for all new clinical staff.

The facility policy and MMP resource folders remain accessible in every inpatient ward at BLH and updated versions of the MMP lanyard card are currently being processed.

7. **Striving for Best Practice**
According to the National Standards, all patients should have a best possible medication history documented (4.6.1) and the medication history and current clinical information should be available at the point of care (4.6.2). The improvements made throughout this project indicate Bankstown-Lidcombe Hospital's commitment to achieving best practice and reducing medication errors as a result.

**INNOVATION IN PRACTICE AND PROCESS**
The process of medication reconciliation has historically been perceived as solely pharmacy driven. This project successfully demonstrated that medication reconciliation is the responsibility of the clinical workforce in conjunction with the patient and their carer and the processes implemented have supported the multidisciplinary approach to medication reconciliation.

**APPLICABILITY TO OTHER SETTINGS**
Plans to make the MMP available electronically when Electronic Medication Management is put into operation at Bankstown-Lidcombe Hospital are underway. It is expected that prescribers will be able to directly populate the list of medications from the BPMH to the NIMC, further reducing the potential for medication discrepancies to occur.

The methods used to implement this project at Bankstown-Lidcombe Hospital are directly applicable to all hospitals in Australia who can learn from the multidisciplinary and patient-centred approach that was applied at Bankstown-Lidcombe Hospital. Bankstown-Lidcombe Hospital has been providing strategic direction to other NSW hospitals on a regular basis as well as sharing poster designs and education packages with other NSW Health entities to ensure results are reproducible in other hospitals.

**F. REFERENCES**


A. AIM

The aim of this project was to establish an integrated and coordinated model of care for children with complex medical needs at The Royal Children’s Hospital (RCH). The expected outcomes were to improve quality of care for these patients and their families and efficiently use hospital resources.

B. SUMMARY ABSTRACT

Background: It is an international and growing phenomenon that a small proportion of patients with complex healthcare needs can use a disproportionately large amount of healthcare services (Berry et al., 2013). As a result of medical advances and technology improving the life expectancy for previously life threatening conditions, the number and proportion of complex patients are increasing (Burns et al., 2010). The delivery of healthcare has not kept up with the changes required to meet the needs of this growing population of children and it will not be sustainable to continue to care for complex patients within our current healthcare systems. Literature review and benchmarking clearly indicate that there are efficiencies to be gained by improving the models of care, systems and workforce utilisation strategies used to care for these patients (Cohen et al., 2011).

Providing care for children with complex and intensive healthcare needs is not straightforward. Clinical decision making is more complicated and providing quality care means trying to link and coordinate services, not only within the RCH system, but across multiple care provider systems. These children have many teams and services involved in their care which are not connected and as a result often experience fragmented, uncoordinated and crisis driven care, with a tendency to over-treat the child and to inadequately support the child’s family (Berry et al, 2013). A paradigm shift is necessary to move from a service-driven model to a consumer-driven model of care with the patient and their family at the centre.

Setting: At RCH approximately three per cent of patients account for 15 per cent of entire hospital bed days. There are many specialist services to care for complex patients; however these specialist services are often unit or organ specific and/or ring-fenced by program boundaries. This constrains service delivery, creates duplication of effort and information and adversely impacts the consumer experience. These complex patients often have many specialists involved in their care with no clear clinical lead coordinating care and treatment. In response to this growing problem the RCH initiated a project and convened a steering committee to investigate and pilot a new and innovative model of care, known as the Complex Care Service (CCS).

Diagnostics and solutions design: The diagnostics and solutions phases of the project were conducted over a six-month period. The diagnostics were robust and consisted of data analysis, process mapping, issue identification and gap analysis sessions conducted with multidisciplinary staff. Consumer consultation and direction was sought by conducting semi-structured interviews with current complex patients and families, reviewing of over 50 complaints from complex patient and families and consulting with the RCH Family Advisory Council. Literature review and benchmarking were undertaken to review evidence of best practice in this area.

During the diagnostic phase three key areas for improvement were identified:

1. family partnership in care
2. care coordination, both within RCH and across community services
3. timely access to ambulatory advice and proactive support.

These three key areas for improvement became the primary drivers of service development and the tangible interventions were identified using a driver diagram analysis (Appendix 1). These interventions were prioritised using an impact-effort matrix by the steering committee and then quantified or qualified with voice of customer and data analysis, laying the foundations of the pilot program (Appendix 2).

Scope: The RCH defined complex care children by utilising four cardinal domains, as outlined by Rosenbaum et al. (2008), to describe complexity in healthcare needs as outlined below:
1. Chronicity: Child’s condition is expected to last at least six months
2. Complexity: Involvement of, or anticipated need for, three or more medical specialties
3. Fragility: The child has had five or more admissions in the past year or is anticipated to need this e.g. neonate
4. Intensity of care: Functional difficulty resulting in interventional healthcare needs. e.g. tracheostomy tube
(Patients must fit all criteria to be eligible.)

Phase 1 (Pilot): The complex care pilot program enrolled 20 patients with complex healthcare needs between March and June 2014. The patients were identified using hospital administration data of existing Respiratory, Developmental Medicine and Nephrology patients that met the above four criteria. Clinician input was then sought to determine eligibility.

Patients enrolled were diverse in age, geographic location and medical conditions. English proficiency did not limit access to the pilot program. Baseline data was collected on their bed days, ED presentations, inpatient admissions and Specialist Clinic appointments. Families also completed a survey to understand their experience of care across 15 components of service provision. These patients and their families were supported by the complex care pilot program for a period of six months (July – December 2014) and during this time there was regular consultation with families and staff to ensure flexible and responsive development of service provision.

A detailed evaluation plan demonstrated specific actions of the program that had direct impact on service provision resulting in a 30 per cent improvement in the patient and family experience of care leading to a better quality of life and more efficient use of RCH resources, specifically a 45 per cent reduction in bed days and a 43 percent reduction in Emergency Department (ED) presentations.

Phase 2 (Expansion): As a result of the pilot’s success, establishment and transition funding for service expansion was supported for the next two years. The RCH CCS is currently expanding to provide support for up to 200 patients and their families. The implementation plan for expansion of service provision is a considered and measured approach spanning two years, planned in two distinct stages. The first stage is focusing on building sustainable systems within and across organisations to support further spread of this work; and the second stage will focus on proofing these systems and developing partnerships with community providers. This staged approach includes regular evaluation and review phases, including consumer consultation.

To date the results of the expansion have mirrored the pilot results with improved experience of care and satisfaction of consumers with a significant reduction in the use of hospital resources.
A. AIM
Our initiatives aimed to address and reduce medication incidents with targeted, designation-specific and site-specific education and learning using retrospective clinical incidents and pharmacists’ intervention data.

The primary objective was to obtain an in-depth understanding of the pharmacists’ clinical interventions and a thorough evaluation of the potential impact of these interventions in preventing Medication-Related Problems (MRP). An additional objective was to investigate all reported clinical incidents by analysing the trends of medication incidents to uncover common types of errors and any trends within our specialist women and newborn health service.

Lastly, we explored how multifaceted strategies and reflective targeted education and learning could provide a continuous feedback loop to staff on common medication-related problems with the goal of preventing future incidents.

B. SUMMARY ABSTRACT
Pharmacist Clinical Interventions
Pharmacist interventions are explained as “any professional activity by the pharmacist directed towards improving the quality use of medicines and resulting in a recommendation for a change in the patient’s medication therapy, means of administration or medication-taking behaviour” (SHPA 2013). A retrospective study involving data analysis of all interventions documented by pharmacists was performed (between Jan 2005-Dec 2014. All clinical interventions documented were evaluated to primarily identify common medications involved within each specialty area (neonatology, obstetrics and gynaecology), and to assess the risks of the Medication Related Problems (MRPs) likely to have been prevented; as well as to obtain institution specific MRPs for future staff education.

Data analysis of pharmacist interventions also revealed trends that allowed planning of continuous improvement activities that would positively impact patients’ health outcomes. The recorded interventions were collated according to ward, medication involved, description of the intervention, and the risk classification. The compiled results were presented to all clinical staff as a self-directed learning presentation as well as ward area in-service sessions. Staff were invited to provide satisfaction feedback on the collated results and presentations.

Medication Incident Reporting
The reporting of clinical incidents is managed and monitored by the hospital risk management coordinator via the state-wide Clinical Incident Management System (CIMS). Trends of all incidents are analysed and strategies to prevent future incidents are discussed and put in place. We performed an in-depth analysis of all medication incidents every two months for 12-months with a thorough discussion on the trends of incidents, common types of incidents and ways to improve medication management to prevent future incidents.

All medication incidents are subsequently presented at the following hospital committee meetings: Drug and Therapeutics Committee, Medication Safety Review Group, Antimicrobial Stewardship Group, Neonatal Coordinating Group, Patient Identification Committee, and the Pharmacy clinical meeting to disseminate the investigation and outcome of the error and the strategies to prevent future occurrences.

The in-depth investigation and analysis of medication incidents has led to many positive outcomes. Strategies put in place to reduce medication incidents include: changes to some clinical practice processes and guideline review and education, for example, a review of the Dosing Guideline to avoid confusing dosing regimens; avoiding look-a-like drugs by changing medication
packaging with the manufacturer, ‘The Reporting of Medication Incidents’ and ‘Near Misses’.

At the resident medical officers’ orientation, medication-related problems including prescribing errors that are common, relevant or have had a significant potential for harm, are presented using real-life examples to junior doctors, followed by an open discussion of the incidents. A self-directed learning package developed and delivered by a resident medical officer and a clinical pharmacist on medication-related problems is also available with additional education sessions carried out through the department of Postgraduate Medical Education (PGME) for existing medical employees. The number of incidents reported after the introduction of these education initiatives reduced significantly over the next 6 months (see figure 11).

Other methods of disseminating the information on medication-related problems in the hospital include a Pharmacy Newsletter, ward in-service sessions and notice board displays highlighting the number of incidents in specific ward areas compared to the incident occurrence organisation-wide.

**Targeted Education**

We projected that our speciality-specific targeted education may have a greater impact on reducing prescribing errors and improving staff satisfaction by utilising this multifaceted interdisciplinary approach. Pharmacists have traditionally provided medication education based largely on generic prescribing errors, rather than institution or speciality specific examples. The organisation implemented this range of strategies to enable and encourage targeted, reflective learning to staff members using real-life examples to address medication incidents with the goal of preventing future medication incidents.

The speciality-specific education sessions are very well received by the staff members in the hospital. A satisfaction survey conducted in September 2015 demonstrated that in general staff from various health professionals enjoyed the self-directed learning package and benefited from the site specific medication clinical incident data.

**Conclusion**

These studies demonstrated that hospital pharmacists contribute to the reduction of Medication-Related Problems including some potentially fatal adverse medicine events. The analysis of medication clinical incidents promotes reflective learning and helps to identify institutional and speciality-specific medication related problems. A continued innovative strategy by multidisciplinary team members is required to augment and reinforce the safe use of medicines.

Pharmacists are well equipped to identify common, recurring prescribing errors and design educational sessions to target these. By designing education sessions integrating pharmacist knowledge with the needs and expectations of clinical staff, we have provided a more effective prescriber education programme. The flow on effect of targeted, specific, integrative education is a focus on continuous improvement and methods to effectively improve patient safety by reducing the harm caused by medication errors. Subsequently, hospital medication incidents continue to be analysed post education interventions for up to date trends in reported medication incidents.

Our interdisciplinary education model demonstrates many benefits including high satisfaction rates. We propose utilising this interdisciplinary, targeted approach as a tool to address site-specific issues with this model being potentially adaptable across a range of settings and professions.
### Category: Clinical Excellence and Patient Safety

#### Table of Submissions

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Mater Hospital</td>
</tr>
<tr>
<td></td>
<td>Quality Improvement Unit</td>
</tr>
<tr>
<td></td>
<td>Paul Morgan, Patrick Coleman, Cintia Martinez, Anoja Gunaratne, Sandy Middleton</td>
</tr>
<tr>
<td></td>
<td>Cognitive Early Detection, Assessment, Recognition and Response (CEDARR) Project</td>
</tr>
<tr>
<td></td>
<td>National Capital Private Hospital</td>
</tr>
<tr>
<td></td>
<td>Quality Team</td>
</tr>
<tr>
<td></td>
<td>Elizabeth Poiritt, Shayne Logue, Leanne Mackinnon, Jennifer Sanchez</td>
</tr>
<tr>
<td></td>
<td>Reducing hospital length of stay while improving functional outcomes for patients admitted to the rehabilitation unit at Calvary Hospital in the ACT</td>
</tr>
<tr>
<td></td>
<td>Calvary Public Hospital Bruce</td>
</tr>
<tr>
<td></td>
<td>Aged Care and Rehabilitation Unit</td>
</tr>
<tr>
<td></td>
<td>Jennifer Azurin, Caroline Fargher</td>
</tr>
<tr>
<td></td>
<td>A virtual clinic: Cutting distance, empowering patients</td>
</tr>
<tr>
<td></td>
<td>Hunter New South Wales Health Local Health District</td>
</tr>
<tr>
<td></td>
<td>Greater Newcastle Cluster Diabetes Service</td>
</tr>
<tr>
<td></td>
<td>Marion Hawker, Susan Neuner, Rosalie Arnold, Michelle Kriss, Shamasunder H Acharya</td>
</tr>
<tr>
<td></td>
<td>GRACE and New South Wales Ambulance enhanced Collaboration</td>
</tr>
<tr>
<td></td>
<td>Hornsby Hospital</td>
</tr>
<tr>
<td></td>
<td>Emergency aged care (GRACE) Geriatric Rapid Acute Care Evaluation</td>
</tr>
<tr>
<td></td>
<td>Nadia Yazdani, Michelle Shiel, Jonathon Tunhavasana</td>
</tr>
<tr>
<td></td>
<td>Let’s Wed and See – Promoting Optimisation of Antimicrobials via the Marriage of GuidanceMS and the eMMS Prescribing System</td>
</tr>
<tr>
<td></td>
<td>Prince of Wales Hospital Pharmacy</td>
</tr>
<tr>
<td></td>
<td>Julie Mansy, Lucy Lin, Ross Vergios, Joanne Rimington</td>
</tr>
<tr>
<td></td>
<td>JETS: JMO Evening Team Staffing</td>
</tr>
<tr>
<td></td>
<td>Liverpool Hospital</td>
</tr>
<tr>
<td></td>
<td>Medical Administration</td>
</tr>
<tr>
<td></td>
<td>Robynne Cooke, Jenelle Matic, David Massasso, Tim West, Russ Schedlich, Michael Njovu</td>
</tr>
<tr>
<td></td>
<td>Implementation of Stereotactic Body Radiotherapy (SBRT) for Lung, Liver, &amp; Bone Metastases with Dual Benefits: providing improved patient outcomes &amp; increasing access for more courses per year.</td>
</tr>
<tr>
<td></td>
<td>Royal North Shore Hospital</td>
</tr>
<tr>
<td></td>
<td>Radiotherapy Unit, Northern Sydney Cancer Centre</td>
</tr>
<tr>
<td></td>
<td>Carolyn McGreggor</td>
</tr>
<tr>
<td></td>
<td>The EPIC Project (Excellent Practice in Communication)</td>
</tr>
<tr>
<td></td>
<td>Nursing Clinical Handover Improvement Practices among acute inpatients</td>
</tr>
<tr>
<td></td>
<td>Liverpool Hospital</td>
</tr>
<tr>
<td></td>
<td>Clinical Nurse Consultant (CNC) Research Group</td>
</tr>
<tr>
<td></td>
<td>Kylie M. Wright</td>
</tr>
<tr>
<td></td>
<td>There is an ‘eye’ in team. Experiences of merging two emergency departments</td>
</tr>
<tr>
<td></td>
<td>Sydney Sydney Eye Hospital</td>
</tr>
<tr>
<td></td>
<td>Sydney/ Sydney Eye Emergency Department</td>
</tr>
<tr>
<td></td>
<td>Angela Duncan, Danielle Newman</td>
</tr>
<tr>
<td></td>
<td>Person-Centred Nursing Orientation</td>
</tr>
<tr>
<td></td>
<td>Sydney/ Sydney Eye Hospital</td>
</tr>
<tr>
<td></td>
<td>Clinical Nursing Services Department, Sydney/Sydney Eye Hospital and Clinical Practice Improvement Unit (CPUI), Prince of Wales Hospital</td>
</tr>
<tr>
<td></td>
<td>Lynnette Higgs, Kettty Rivas, Agnes Shea</td>
</tr>
<tr>
<td></td>
<td>Improving the Management and Outcomes of Elderly Patients with Hip Fractures</td>
</tr>
<tr>
<td></td>
<td>Albury Wodonga Health</td>
</tr>
<tr>
<td></td>
<td>Orthopaedic Unit: Surgical Ward 1</td>
</tr>
<tr>
<td></td>
<td>Jenny Furness, Lynne Frost, Elie Khoury, Jeremy Kolt, Franz Eversheim, Hong Yu, Barbara Robertson, David Lawrence</td>
</tr>
<tr>
<td></td>
<td>Perineal Protection</td>
</tr>
<tr>
<td></td>
<td>Bankstown-Lidcombe Hospital</td>
</tr>
<tr>
<td></td>
<td>Maternity Services</td>
</tr>
<tr>
<td></td>
<td>Rebecca Moore, Ronia Awick, Pauline Kelly, Renae Hains, Amanda Vujanovic</td>
</tr>
<tr>
<td></td>
<td>Doctors, Pharmacists, Nurses, Administrative staff, Patients and Carers –the new multidisciplinary team</td>
</tr>
<tr>
<td></td>
<td>Bankstown-Lidcombe Hospital</td>
</tr>
<tr>
<td></td>
<td>Lucy Nair, Karma Meekhail, Natalie Raffoul, Wendy Harmer, Chris Leahy, Caroline Farmer, Linda Campbell</td>
</tr>
<tr>
<td></td>
<td>Hourly Patient Rounding –building relationships</td>
</tr>
<tr>
<td></td>
<td>CCLHD</td>
</tr>
<tr>
<td></td>
<td>MAU</td>
</tr>
<tr>
<td></td>
<td>Tracy Southwood</td>
</tr>
<tr>
<td></td>
<td>Knees Up… It’s Hip to be Educated – a Compulsory Joint Education Program</td>
</tr>
<tr>
<td></td>
<td>Northern Beaches Health Service – Northern Sydney Local Health District</td>
</tr>
<tr>
<td></td>
<td>Mona Vale Hospital</td>
</tr>
<tr>
<td></td>
<td>Deb Stewart, Samantha West, Rachelle Foxton, Angela Hermes, Joane Eagleton</td>
</tr>
<tr>
<td></td>
<td>Aiming to Localise Long-term Innovation to Achieve Networks within the Community including E-health (ALLIANCE)</td>
</tr>
<tr>
<td></td>
<td>South Western Sydney Local Health District</td>
</tr>
<tr>
<td></td>
<td>Wollondilly Health Alliance, Clinical Innovation &amp; Business Unit</td>
</tr>
<tr>
<td></td>
<td>Josephine Chow, Luke Johnson, Paige Blanton, Rane Pennock, Justin Duggan, Ally Dench, Anna Phan</td>
</tr>
<tr>
<td></td>
<td>How does the anxious patient benefit from a Pre Admission visit in our acute care facility</td>
</tr>
<tr>
<td></td>
<td>St Vincent’s Private Hospital Sydney</td>
</tr>
<tr>
<td></td>
<td>Pre Admission Centre</td>
</tr>
<tr>
<td></td>
<td>Eilish Hoy, Laura Hunter</td>
</tr>
<tr>
<td></td>
<td>St Vincent’s Private Hospital Sydney, raising the bar in Breast Cancer related lymphoedema; L-Dex™ is best!</td>
</tr>
<tr>
<td></td>
<td>St Vincent’s Private Hospital Sydney</td>
</tr>
<tr>
<td></td>
<td>Breast Care Nurse Clinical Nurse Consultant</td>
</tr>
<tr>
<td></td>
<td>Deborah Maguire</td>
</tr>
<tr>
<td></td>
<td>St Vincent’s Private Hospital Sydney, raising the bar in Breast Cancer related lymphoedema; L-Dex™ is best!</td>
</tr>
<tr>
<td></td>
<td>St Vincent’s Hospital Sydney</td>
</tr>
<tr>
<td></td>
<td>Breast Care Nurse Clinical Nurse Consultant</td>
</tr>
<tr>
<td></td>
<td>Deborah Maguire</td>
</tr>
<tr>
<td></td>
<td>St Vincent’s Health Australia: Thermal Care Collaborative</td>
</tr>
<tr>
<td></td>
<td>St Vincent’s Health Australia</td>
</tr>
<tr>
<td></td>
<td>Private and Public Divisions</td>
</tr>
<tr>
<td></td>
<td>Don’t Restrict My Ability – Restricted Weight Bearing in Orthopaedics</td>
</tr>
<tr>
<td></td>
<td>SLHD</td>
</tr>
<tr>
<td></td>
<td>Orthopaedics</td>
</tr>
<tr>
<td></td>
<td>Megan White, Breda Doyle, Tim Sinclair, Nichola Boyle, Jai Sungaran, Peter Walker, Priya Nathan</td>
</tr>
<tr>
<td></td>
<td>Novel approaches for delivering and promoting HIV testing to gay men in Inner West Sydney</td>
</tr>
<tr>
<td></td>
<td>Community Health Sydney Local Health District</td>
</tr>
</tbody>
</table>

The Australian Council on Healthcare Standards
19th Annual ACHS Quality Improvement Awards 2016
Sydney Local Health District, Community Health, Sexual Health Service
Brooke Rhiannon Dailey, A/Prof Catherine O’Connor, Renee Moreton, Sue Amanatidis, A/Prof David Templeton, Nicky Sharp

Integrating Electronic Prescribing – A New Model for Targeted Patient Care
Royal Darwin Hospital
Quality Unit in conjunction with Pharmacy Department and Health Informatics
John Shanks, Toby Maddern, Kylie St George, Anna Ralph, Joanna Wallace

The Power of Consumers Auditing Clinical Handover (CH)
Royal Brisbane and Women’s Hospital
Safety and Quality Unit
Lisa Mitchell, Helena Lake, Faileen James

Reducing the incidence of falls for Infant and Toddlers at Ellen Barron Family Centre
Children’s Health Queensland Hospital and Health Service
Ellen Barron Family Centre, Child and Youth Community Health Service
Denyse Hayes, Catherine Marron

Lift the Lip Browns Plains Pilot Project - Improving Access to Oral Health Care for Children 0 – 5 Years of Age
Children’s Health Queensland Hospital and Health Service (in conjunction with Metro North Hospital and Health Service, Metro South Hospital and Health Service)
Child & Youth Community Health Service, Metro North Oral Health Services, Metro South Oral Health Service
Alison Dickinson, Margaret Pukulis, Nicola Sutton

Continuing Quality Improvement in Computed Tomography
Gold Coast Hospital and Health Service
Medical Imaging
Timothy Ireland, Daniel Martin, Deborah Tout, James Rogers, Mitchell Ashton, Natalia Diaz

West Moreton - Hospital at Night
Ipswich Hospital – West Moreton Hospital and Health Services
Hospital at Night/ Hospital After Hours
Sara Riggs

Improving Nutritional Intake in Hospital
Royal Brisbane and Women’s Hospital
Nutrition and Dietetics, Allied Health Professions
Adrienne Young, Merrillyn Banks, Alison Mudge, Jennifer Ellick, Philip Juffs

HOP After school hours adolescent pain management program: Implementing evidence based practice to establish a group program to support adolescents who can still attend school.
St Vincent’s Private Hospital Brisbane
Pain Services
Hoiyan Karen Li

Working Together to Connect Care Response Project
Metro North Hospital and Health Service – Royal Brisbane and Women’s Hospital and MNHHS Oral Health Service
Patient Flow and Emergency Department (ED)/ED Frequent Presenters Response Project Group
Debra Harcourt, Leonie Cartlidge-Gann, Clancy McDonald

Eat Walk Engage – Better care for older hospitalised patients
Royal Brisbane and Women’s Hospital
Eat Walk Engage Program, Internal Medicine Services
Alison Mudge, Mrs Prue McRae, Ms Karen Lee-Steere, Mrs Margaret Cahill, Dr Adrienne Young, Dr Merrillyn Banks, Mr Mark Crucikshank

Translating Evidence to Practice through the Prevention of Catheter Acquired Urinary Tract Infection and Trauma (CAUTIT)
West Moreton Hospital and Health Service
Avis Macdonald, Cheryl Burns

Increasing Access to Quality Endoscopy in Queensland

Metro South Hospital and Health Service
Logan Hospital Endoscopy Unit
Dianne Jones, Lea Wiggins, Lee Poole, Robert Simpson

Implementation of Advance Care Directives and Resuscitation Planning
Central Adelaide Local Health Network
Safety Quality and Risk Management Unit
Virginia Wilkinson, Karen Stead, Karen Court

Improving rehabilitation outcomes through community day leave for forensic patients
Tasmanian Health Service
Forensic Health Services
Ann Marie Mallett, Hannah Miller, Madeleine Nicholls

Prevention of clinical deterioration by developing a new model of care to manage post-operative complications that delay mobilisation in high risk surgical patients: An Advanced Scope of Practice Physiotherapy Role
Austin Health
Physiotherapy
Susan Berney, Danielle Dunlop, Mel Gregory, Debbie Munro

Improving and reviewing Correct Patient, Correct Side and Correct Site practices at Western Health.
Western Health
Perioperative Services
Dianne Buttigieg, Elizabeth Hessian, Patricia Kitney, Oliver Evans

Improving the use of standardised handover tools and best practice principles in the peri operative setting.
Western Health
Perioperative Services
Patricia Kitney, David Bramley, Raymond Tam, Dianne Buttigieg, Oliver Evans

Oral Chemotherapy Clinic – “Improving education and care for cancer patients”
Western Health & Melbourne Health
Cancer Services
Catherine Oakman, Ilana Hornung, Georgina Akers, Kerry Shanahan, Sue Thomas, Paula Nelson, Jayne Watson

Partnering with a local community health organisation to provide rehabilitation to cancer survivors
Western Health
Cancer Services
Meron Pitcher
Ruth Martin, Alice Jermakoff, Roshan Rathnayaka, Tammy Dinh

Simplifying Complex Care
The Royal Children’s Hospital
Complex Care Service
Lisa Stephens, Nick Mtounford, Susan Gibb, Doug Bryan

The Benefits of Sustaining a Streamlined Hip Fracture Management
South West Healthcare
Orthopaedics
Alasdair Sutherland, Tyler Mow, Jennifer Lukeis, Denis O’Leary, Leanne McCann, Nolan McDonnell

Day Rehabilitation Falls and Balance Program –Changes and Improvements
South Eastern Private Hospital – Healthcare
Allied Health – Day Rehabilitation
Hannah Wood, Alex Lan, Caroline Hussey

One Patient is One Too Many: Preventing Hospital-Acquired Venous Thromboembolism
Melbourne Health
Transformation and Quality, Office of the Chief Executive, Pharmacy Department, Department of Plastic Surgery
Stella Kravtsov, Daryl Williams, Joanne Young, Kirstie MacGill

Breastfeeding Circle: outpatient service providing support and advice to postnatal mothers
St John of God Subiaco Hospital
Maternity Services

The Australian Council on Healthcare Standards
19th Annual ACHS Quality Improvement Awards 2016
<table>
<thead>
<tr>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovation in a SAFE Afterhours Team</td>
<td>Lisa Black, Heather Marin, Helen McAllister, Janie Brown, Alannah Cooper</td>
</tr>
<tr>
<td>Safety After Hours for Everyone (SAFE) Department</td>
<td>Katherine Birkett, Deepan Krishnasivam, Tim Bowles</td>
</tr>
<tr>
<td>Ensuring patient safety and quality care in the appropriate use of</td>
<td>Katherine Birkett, Deepan Krishnasivam, Tim Bowles</td>
</tr>
<tr>
<td>blood products and its alternatives at King Edward Memorial Hospital</td>
<td></td>
</tr>
<tr>
<td>a trend review from 2010 – 2015.</td>
<td></td>
</tr>
<tr>
<td>King Edward Memorial Hospital, Women and Newborn Health Service</td>
<td></td>
</tr>
<tr>
<td>Transfusion Medicine/Haematology</td>
<td></td>
</tr>
<tr>
<td>Deborah Pinchon, Madeleine Gallagher-Swann, Nicole Staples, Bernard</td>
<td></td>
</tr>
<tr>
<td>Ingleby, Christine Arnold, Wanda Randall, Andrew Barr</td>
<td></td>
</tr>
<tr>
<td>From reflective learning to action: Reducing medication-related</td>
<td>Stephanie Teoh, Tamara Lebedevs, Nabeelah Mukadam, Amy Fitzgerald, Caroline Kerr, Patrick Yapp,</td>
</tr>
<tr>
<td>problem with an innovative, interdisciplinary, site-specific,</td>
<td>Michael Petrovski</td>
</tr>
<tr>
<td>targeted education model</td>
<td></td>
</tr>
<tr>
<td>Women and Newborn Health Service</td>
<td></td>
</tr>
<tr>
<td>King Edward Memorial Hospital - Department of Pharmacy, Department</td>
<td></td>
</tr>
<tr>
<td>of Safety, Quality and Performance, Medication Safety Review Group,</td>
<td></td>
</tr>
<tr>
<td>Department of Postgraduate Medical Education, Antimicrobial</td>
<td></td>
</tr>
<tr>
<td>Stewardship</td>
<td></td>
</tr>
<tr>
<td>Stephanie Teoh, Tamara Lebedevs, Nabeelah Mukadam, Amy Fitzgerald,</td>
<td></td>
</tr>
<tr>
<td>Caroline Kerr, Patrick Yapp, Michael Petrovski</td>
<td></td>
</tr>
<tr>
<td>Sustaining Improvement in the management of the Endoscopy Waitlist</td>
<td>Anne MacDonald, Clare Matthews, Michael Levitt, Hooi Ee, Dev Segarajasingam</td>
</tr>
<tr>
<td>Osborne Park Hospital Ambulatory Service</td>
<td></td>
</tr>
<tr>
<td>&quot;WISER&quot; (We Innovate, Service Excel Regularly) Movement in a Cluster</td>
<td>New Territories East Cluster (NTEC), Hong Kong</td>
</tr>
<tr>
<td>of 7 Hospitals</td>
<td></td>
</tr>
<tr>
<td>&quot;WISER&quot; (We Innovate, Service Excel Regularly) Movement in a Cluster</td>
<td>Hing Yu So, Babbitt Woun, Mandy Tsang, Joan Man, Hon Ming Cheung, Chi Tim Hung</td>
</tr>
<tr>
<td>of 7 Hospitals</td>
<td></td>
</tr>
<tr>
<td>Success at Joondalup Health Campus through the introduction of an</td>
<td></td>
</tr>
<tr>
<td>innovative Patient Blood Management Program</td>
<td></td>
</tr>
<tr>
<td>Osaka Park Hospital Ambulatory Service</td>
<td></td>
</tr>
<tr>
<td>Quality Department</td>
<td></td>
</tr>
<tr>
<td>Diana McCubbin</td>
<td></td>
</tr>
<tr>
<td>Effecting change: Integrating consumer / clinician feedback</td>
<td>Royal Brisbane &amp; Women’s Hospital</td>
</tr>
<tr>
<td>Royal Brisbane &amp; Women’s Hospital</td>
<td>Departments of Intensive Care Services &amp; Speech Pathology</td>
</tr>
<tr>
<td>Karyn Heineger, Sonia Baker, Nanette Paxman, DR Robert Boots,</td>
<td></td>
</tr>
<tr>
<td>Lynnell Bassett</td>
<td></td>
</tr>
<tr>
<td>Implementation of Patient Controlled Epidural Analgesia (PCEA) in</td>
<td>St John of God Subiaco Hospital</td>
</tr>
<tr>
<td>Labouring Women</td>
<td>Department of Anaesthesia and Pain Medicine</td>
</tr>
<tr>
<td>Jill Kelly, Nolan Mcdonell, Yvonne Buller</td>
<td></td>
</tr>
<tr>
<td>Prehospital Thrombolysis - Despite the Distances: Improving</td>
<td>Hunter New England Health</td>
</tr>
<tr>
<td>Healthcare in Regional &amp; Rural Areas.</td>
<td>John Hunter Hospital: Cardiology Department</td>
</tr>
<tr>
<td>Professor Andrew Boyle, Professor Peter Fletcher, Trent Williams,</td>
<td></td>
</tr>
<tr>
<td>Lindsay Savage, Arshad Khan, Rohan Bhagwandeen</td>
<td></td>
</tr>
<tr>
<td>Integration of care across the patient continuum</td>
<td>Logan Hospital</td>
</tr>
<tr>
<td>Department of Respiratory Medicine</td>
<td></td>
</tr>
<tr>
<td>Khoo Tran, Michele Hellen, Veenu Mubarak, Tim Ryder, Alissa Knight,</td>
<td></td>
</tr>
<tr>
<td>Brett Windeatt, Sharna Wilkinson, Allison Murdoch</td>
<td></td>
</tr>
</tbody>
</table>
A. AIM
The aim of the Good Start to Life project is to co-design with Maori and Pacific Islander consumers in Queensland a culturally-tailored maternal and newborn health strategy to promote appropriate maternal nutrition, healthy weight gain in pregnancy and recommended infant nutrition guidelines.

B. SUMMARY ABSTRACT
The Good Start Program is a Children’s Health Queensland Hospital and Health Service Initiative which aims to improve the health and wellbeing of Maori and Pacific Islander children and families in Queensland. The program targets seven of the largest Maori and Pacific Islander communities – Maori, Samoan, Tongan, Cook Islander, Fijian, Fiji Indian, and Papua New Guinean.

Maori and Pacific Islander adults in Queensland experience significantly higher rates of chronic disease and overweight/obesity compared to the rest of the Queensland population (Queensland Health 2010 & Queensland Health 2012). The trend is also seen in Maori and Pacific Islander children in Queensland (Queensland Health 2010 & Queensland Health 2012). Health and wellbeing from the antenatal period through the first 3 years of life is now well understood to lay the foundations for long-term health outcomes (Children’s Health Queensland Hospital and Health Services 2015). Addressing childhood obesity during the perinatal period and throughout infancy has been found to contribute to reducing the prevalence of chronic disease and obesity (Children's Health Queensland Hospital and Health Services 2015).

In 2015, Metro South Hospital and Health Services identified a high prevalence of gestational diabetes mellitus in Maori and Pacific Islander women with rates more than double the state-wide average (16% vs. 7.6%) (Queensland Health 2015). Maori and Pacific Islander mothers birthing at Logan Hospital exhibit overweight/obesity at a rate of 66%, compared to 46% in the non-Maori and Pacific Islander population (Queensland Health 2015). Similar inequities are apparent at Redland and Cairns Hospitals (Queensland Health 2015). The lack of culturally appropriate antenatal and child health care services/resources, low levels of health literacy and a strong cultural reluctance to seek support presents challenges in addressing these key health issues and ultimately childhood obesity within the Maori and Pacific Islander community (Queensland Health 2011).

In order to appropriately address maternal and childhood health inequalities in the community, the Good Start Program established a consumer engagement strategy and subsequently created the Good Start to Life project. Good Start to Life is an important preventative health strategy that supports Maori and Pacific Islander women to gain a healthy amount of weight during pregnancy, breastfeed and adopt recommended infant nutrition guidelines.

It was vital for the Good Start program team to involve Maori and Pacific Islander health consumers in co-designing the project. Different engagement approaches have been used in the form of forums, steering committee, consumer review groups and consumer participants groups. Each method required different time investment, education background, literacy level or personal involvement. This strategy has provided the opportunity for all health consumers to be part of the project in a flexible and accommodating manner. 95 health consumers have been directly involved in the development of the Good Start to Life project having dedicated a total of 133 hours in the form of consultation or co-designing activities.

The initial stage of the Good Start to Life project has been completed with the creation of a series of educational booklets and posters that prioritised key areas identified as contributing to childhood
C. REPORT

APPLICATION OF ACHS PRINCIPLES

1. Consumer Focus
As presented in the diagram below, the development of the Good Start to Life project was structured in such a way that it had to be co-designed for and by Maori and Pacific Islander health consumers. The consumer engagement process was designed to ensure health consumers felt valued and respected. Role and responsibilities were articulated to each consumer and consent was gained. The Good Start Program continuously records consumer engagement in a register with dates, time, engagement activities and outcomes. The register is shared with all health consumers in a transparent manner to ensure they understand how their contributions have been incorporated into the project. In order to thank consumers for their invaluable contribution and foster future consumer activities, a culturally tailored personal letter was provided to each consumer (Appendix 3).

In the Good Start to Life project, health consumers have been involved at two different levels.

Consultation
Queensland Health Survey in 2007/2008: This consultation has identified that health literacy is found to be very poor among all Pacific Islander communities with low knowledge about health and health services. The low levels of knowledge about health and services are largely related to poor system navigation skills in the community. Pacific Islander communities are disengaged from the mainstream service sector and are reluctant to seek help. They identify themselves as generally reserved, shy and ashamed to seek assistance from services and this is one of the primary factors in communication barriers, lack of uptake on preventive health and self-management. This consumer feedback has been incorporated into the design of the Good Start to Life by building cross-cultural capacity of health services and supporting consumers to seek help. The literacy level, cultural appropriateness and language used in the Good Start to Life resources have been adapted following the recommendations from this survey.

Maternal and Newborn Health Forum in 2016: The Good Start program supported Metro South Hospital and Health Services to organise a health consumer forum with the aim of developing an assessment on the needs of maternal and newborn services for Maori and Pacific Islander families in Queensland (Appendix 4). The data collected is currently being analysed and will feed into Good Start to Life strategic directions.

Co-designing
Good Start Program Steering Committee: The monthly steering committee is a high level strategic meeting comprising of Children’s Health
Queensland directors, preventative health experts and health consumers. Five health consumers from differing Maori and Pacific Islander cultural backgrounds are actively involved in the committee. The meetings are utilised to decide on strategic directions, planning, implementation and evaluation of the Good Start to Life project. The meetings are set up as a true co-design process with health consumer input and contributions considered equal to any other committee member. An induction for consumers is provided before their first meeting and more time is always allocated after each meeting should they need additional information.

**Good Start to Life health consumer working group:**
Local Maori and Pacific Islander mothers and fathers of young children (0 – 4 years of age) were engaged through connections within community networks to review and/or be featured in Good Start to Life resources. Telephone calls and emails were utilised to arrange meetings and consultations with consumers. With strong knowledge of culturally appropriate practices by the multicultural workforce, it was necessary to ensure consultations (particularly initial consultations) were made face-to-face, in a location easily accessible and selected by the consumer. To ensure feedback was applicable, consumers were briefed about the project prior to initially viewing the resources to ensure they had a better understanding about the scope of the project. Consumers were encouraged to provide feedback as well as recommendations for the resources in regards to cultural appropriateness, literacy level, and content and imagery suitability. Initial and follow-up consultations with consumers were conducted. Each consultation was approximately two-hours to ensure adequate time was allocated to read the resources and provide feedback. As all initial consultations were conducted face-to-face, it was important to be considerate of the consumer’s time invested in providing feedback. Therefore a follow-up consultation was offered face-to-face, via email or telephone communication. Overall, a total of approximately 20 hours was consumed with community members to obtain feedback and valuable recommendations.

**Good Start to Life health consumer participants:** Due to the cultural sensitivity around maternal and infant health, locally based photographers from the Maori and Pacific Islander community were actively sought to recruit Maori and Pacific Islander consumers from the targeted demographic that were willing to be photographed and featured in the resource. It can be noted here that recruited consumers for all areas of the resources, honestly and accurately reflected the area or topic in which they were utilised throughout the resources. In total, 44 consumers of various Maori and Pacific Islander cultural backgrounds (Maori, Samoan, Tongan, Cook Islander, Papua New Guinean, Fijian and Fiji Indian) were photographed. A total of approximately 105 consumer engagement hours was logged during the photography shooting process resulting in a total of 991 edited photos.

2. **Effective Leadership**
In 2008-09 the Queensland Government prioritised Pacific Islander populations as a whole-of-government priority group as a way to start addressing their relative social disadvantage. Queensland Health’s response to this prioritisation was to conduct an assessment to understand health needs and priorities so that an effective response can be developed. 191 health consumers were consulted through this process. One of the main
recommendations resulting from this assessment was to allocate a Maori and Pacific Islander multicultural health workforce that could understand and address cultural and linguistic barriers.

Children’s Health Queensland Hospital and Health Service acted on health consumers recommendations through the creation of the Good Start Program in 2011. The program is now a state wide specialised service that employs health professionals and health workers from Maori and Pacific Islander cultural background.

The Good Start to Life project commenced as result of a needs assessment which identified that no current model of care existed for Maori and Pacific Islander maternal health in Australia. The commencement of this project established the Good Start Program as the leading department in maternal and infant nutrition for Maori and Pacific Islanders in Queensland.

Developing the first maternal and infant nutrition resources for Maori and Pacific Islander families in Australia required an innovative and creative approach. A community based, health consumer focused approach ensured that national standards and best practice guidelines were reflected in the resources in a culturally appropriate and effective manner. The development phase of the Good Start to Life resources motivated the workforce to undertake professional development and encouraged them to contribute to the project. These key factors fostered health consumers, community and workforce ownership and the resulting resources were unique in their content and design.

3. Continuous Improvement

A cyclic continuous improvement methodology (Appendix 5) was utilised in the development of the Good Start to Life resources. In 2015, Children Health Queensland systematically reviewed maternal and infant nutrition resources available in Australia and identified numerous consumer resources (government and non-government) and found that 0% of consumer resources are highly recommended, 23% partially recommended and 77% were not recommended (Children’s Health Queensland Hospital and Health Service 2015). Additionally, the review highlighted the gap in culturally appropriate perinatal consumer resources with zero resources specifically targeting the Maori and Pacific Islander priority population group (Children’s Health Queensland Hospital and Health Service 2015). Based on the findings of the review, the Aboriginal and Torres Strait Islander resource Growing Strong: Feeding You and Your Baby was recognised by both health professionals and consumers as providing valuable information in a culturally appropriate format.

Combining evidence from the review, best practice guidelines, evaluation outcomes and cultural expertise, Growing Strong: Feeding You and Your Baby provided a foundation for the development of the Good Start to Life resources for Maori and Pacific Islander families. Applying that research to draft the initial version of the resources was the first step in the improvement strategy. Multiple working groups were then established to analyse the resources including:

- Nutrition working group: health practitioners from clinical and preventative health settings
- Community working group: members of the Maori and Pacific Islander community in Queensland (primarily from the target demographic)
- International organisations: members of international public health organisations working with Maori and Pacific Islander communities.

Feedback and recommendations were actively sought from each of the review teams for every aspect of the resources including the content, cultural appropriateness, photography/imagery, graphic design and literacy level. After feedback from each review group was collected the recommendations were collated, evaluated and the draft resources were altered. This process occurred numerous times on a cyclic basis to ensure the resources were continually improved. To maintain continuous improvement, the resources will be evaluated utilising a similar improvement cycle at 2 years post dissemination. This will facilitate ongoing improvement of the resources in the future.

Utilising this strategy fostered inclusive communication from all of the stakeholder groups, enabled stakeholders to make recommendations at every stage of the development and allowed feedback to be incorporated and then re-evaluated. Having working groups from multiple stakeholders also ensured that the resources included content in accordance with national health and nutrition guidelines, be utilised by health professionals in multiple settings, be well understood by consumers and ensured they were culturally appropriate.

Employing the cyclic quality improvement methodology reflects best practice in development of health education resources and resulted in health
consumer, health practitioner and public health organisation satisfaction. The staff involved in the project actively and continuously strove to improve the resources in order to produce high quality health education resources that ultimately work toward improving the health and wellbeing of Maori and Pacific Islander families.

4. Evidence of Outcomes
The literacy level of health resources is a fundamental consideration in the development of a culturally appropriate health education resource. By utilising a partnership between health professionals and health consumers, both technical and cultural expertise was gained resulting in a resource that delivers relevant and necessary content in the appropriate language and literacy level. The literacy demand of the resource was assessed using an electronic readability indicator which encompasses various factors such as writing style, sentence construction and vocabulary requirements of the consumers. Overall, the Good Start to Life resources resulted in a Flesch-Kincaid Grade Level of 4.5 making them a highly recommended resource. This demonstrates the resources are suitable for the target population and highlights the commitment of the Good Start Program in ensuring health consumers are priority.

Health consumers engaged with the Good Start to Life project reported great outcomes with a high level of satisfaction in the way their feedback and recommendations have been incorporated. Consumers also acknowledged the dedication of the Good Start team to take time to listen, understand and utilise the voice of Maori and Pacific Islander health consumers in a culturally appropriate way.

Overall, the project demonstrated excellent consumer engagement outcomes with a total of 95 health consumers involved, 133 hours of engagement and a consistent participation of consumers in monthly meetings noting that none of health consumers have been remunerated.

5. Striving for Best Practice
The Good Start to Life project is founded upon evidence from a combination of literature, current research and clinical practice guidelines, national and international cultural expertise and consumer experience. It has been culturally tailored to the targeted demographic of a vulnerable population group to ensure maximum uptake and improvement of current health issues. Additionally, it has incorporated modern technology in conjunction with cultural knowledge to use a modern visual design format as well as photographs instead of illustrations to create ownership and maximise engagement with consumers.

More importantly, the Good Start to Life project is evidence that ownership of responsibility can result in excellence in performance outcomes. Establishing health consumer, clinical, public health and international working groups generates an effective, accurate and culturally appropriate resource to assist in working towards addressing the needs of a vulnerable population group. The Good Start Program strives to be innovative, flexible and inclusive in its development and communication with consumer and health professional working groups is ongoing.

What distinguishes the Good Start Program apart from other health programs is the recruitment and training of health workers from each of the seven target communities to consult, develop and deliver culturally-tailored initiatives and resources. The Good Start Program demonstrates the pride of the multicultural health workforce in delivering quality service for its consumers, but also Children’s Health Queensland Hospital and Health Services constant drive for greater commitment to best practices.

INNOVATION IN PRACTICE AND PROCESS
The systemic involvement of health consumers in the planning, design and development of the Good Start to Life project is an innovative practice for hospital and health services. Transparency, respect and support of consumers are key factors contributing to the success of this practice.

The establishment of structured engagement processes including induction, engagement register, feedback forms, specific support and acknowledgement have proven to be both innovative and effective. A team culture where by partnering with consumers is considered part of everyday business has been established within the Good Start Program demonstrating innovation and excellence in everyday practices and processes. The success of this approach is even greater considering that the Maori and Pacific Islander community in Queensland is traditionally difficult to engage.

APPLICABILITY TO OTHER SETTINGS
The Good Start to Life project successfully engaged with health consumers and this strategy has the potential to be utilised across a wide range of health services. Consumer engagement is an important aspect of the National Safety and Quality Health Services Standards and so the learnings from this project are applicable to any medical services
seeking to develop a culture of partnership with consumers.

F. REFERENCES

Children’s Health Queensland Hospital and Health Service 2015, Maternal and Infant Nutrition Resource Review, State of Queensland (Queensland Health), Brisbane.


Queensland Health 2011, Queensland Health response to Pacific Islander and Māori health needs assessment, State of Queensland (Queensland Health), Brisbane.


Queensland Health 2015, Queensland Perinatal Data Collection, State of Queensland (Queensland Health), Brisbane.
G. APPENDICES

Appendix 1: Good Start to Life Resources – Booklets
The Good Start to Life booklets support health consumers build their knowledge, skills and confidence around optimal maternal and infant nutrition.
Appendix 2: Good Start to Life Resources – Posters

The Good Start to Life posters support health consumers build their knowledge, skills and confidence around optimal maternal and infant nutrition.
Appendix 3: Health Consumer Thankyou Letters
Thankyou letters designed to acknowledge and express gratitude to health consumer participants and working group to maintain consumer ownership for the resources and to foster future participation from the Maori and Pacific Islander community.

Date

Name of recipient
Address
Suburb State Postcode

Dear,

On behalf of the Good Start program and the Child and Youth Community Health Services Children's Health Queensland, I am writing to thank you and your family for taking the time to be involved in the Good Start to Life project.

The success of our project is a reflection of your support and commitment in working towards helping the Maori and Pacific Islander community improve their health and wellbeing. Because of your support we have been able to complete the four Good Start to Life booklets and three supporting posters and are now working on developing education sessions for Maori and Pacific Islander families.

Your enthusiasm in helping the Good Start program is sincerely appreciated. You dedicated your time, welcomed us into your home and shared with us your cultural insight, for which we are truly grateful. It is only with the assistance of community members such as yourself that we can work towards helping Maori and Pacific Islander children, mothers, families and families.

Thank you, malo ‘eupito, vineka yakelevu, whakawhetai katoe, fa‘afetai tele leva, chopiyawad, tenkyu tumas, mentaia maata to you and your family.

Yours sincerely,

Divisional Director
Child and Youth Community Health Service
Children's Health Queensland Hospital and Health Service

[Address details]

[Children's Health Queensland]

[Good Start logo]
Appendix 4: Maternal and Newborn Health Forum 2016
Development of a maternal and newborn health needs assessment of Maori and Pacific Islander health consumers.

Maori & Pasifika Health
Women & Newborn

Where:
Hope Centre International
440 Kingston Rd,
Slacks Creek

When:
Monday 18th April, 2016

Time:
9:30am – 12:30pm

We would like to invite local Maori and Pasifika families to join us for hui, talanoa and lunch. Metro South Health would like to talanoa with you about your pregnancy and childbirth health care and experiences in Queensland and how we can better serve you. We welcome your input and really appreciate your help in making what we do for the Maori and Pasifika families better.

Please RSVP by Monday 4th April for catering purposes to:
➢ Thomas Lilley 0429 649 028 thomas.lilley@health.qld.gov.au
➢ Andrea Cruickshank 0407 604 649 andrea.cruickshank@health.qld.gov.au

The Australian Council on Healthcare Standards
19th Annual ACHS Quality Improvement Awards 2016
Appendix 5: Cyclic Continuous Improvement Methodology
The continuous improvement methodology utilised in the development of the Good Start to Life resources.

**Category: Non-Clinical Service Delivery**

**PLAN**
Needs assessment and review of existing maternal and infant nutrition resources

**DO**
Create a draft series of culturally tailored resources promoting optimal maternal and infant nutrition to Maori and Pacific Islander families

**REVIEW**
Review draft resources with health consumer working group

**ACT**
Alter resources utilising evaluation of feedback and recommendations from health consumers

**EVALUATE**
Evaluate feedback and recommendations from health consumer group with the assistance of best practice guidelines
Highly Commended

St Vincents Public Hospital Sydney
Environmental Services Darlinghurst Campus, St Vincent’s Public Hospital level 9 Xavier South BMT ward, level 7 and 8 Xavier North and South.

St Vincents Hospital Sydney Clean, Reliable, Trustworthy, Proven, Sustained Excellence in Patient & Resident Care – The Environmental Cleaning Review & NSW Blood & Bone Marrow Transplant Cleaning Project
Rob Gordon, Emily Heinen, Joanna Uribe, Kirsten Bruchhauser, Kylie Naudi, Michelle Wilson, Giulietta Pontivivo, Brett Gardiner

A. AIM
In 2014, the St Vincent’s Hospital Sydney (SVHS) Environmental Services Department introduced a new model of cleaning to the Blood and Bone Marrow Transplant (BMT) unit with the aim of improving cleaning practices, patient safety by reducing Healthcare Associated Infections (HAIs) and patient experiences of the unit.

Following an Environmental Cleaning Review, the project involved trialling new environmental cleaning practices and initiatives such as introducing cleaning matrix’s to clearly define roles and responsibilities, frequencies of cleaning based on risk rating and elements of the room, auditor training for cleaners and supervisors using the BMT audit tool, with strong customer services focus.

Following the implementation in the BMT ward, the model was introduced to other clinical units in the hospital, with external audits and benchmarking used to measure progress in improving Environmental Cleaning Standards, education and training tools for clearly defined responsibilities, improved customer and patient feedback on both cleaning and services standards and improvements in HAIs within the wards.

By implementing sustainable, evidence-based and validated systems, the SVHS Environment Service Department have demonstrated the importance of good environmental cleaning, and its contribution to decreasing HAIs, improving patient satisfaction, safety, and as well as providing a visual lift to units for patients, guests and staff.

B. SUMMARY ABSTRACT
In recent years, healthcare facilities and governing bodies have acknowledged that improvements in environmental surface cleaning and disinfection are required to assist in reducing the rates of Healthcare Associated Infections (HAIs) (Jansen & Murphy 2009). Good environmental and infection control practices should consist of essential elements such as careful cleaning and disinfection of surfaces and touch points, use of correct and effective equipment, ensuring cleaning is carried out at correct day and time, and ongoing audit validation of cleaning programs. Multiple studies have shown that manual cleaning and disinfection of surfaces in hospitals without clearly defined processes, roles and responsibilities is suboptimal (Aldeyab et al. 2009; Dancer et al. 2009). In many facilities, only 40 to 50% of surfaces that should be cleaned are wiped by housekeepers (Boyce 2016). In addition, observational methods combined with use of adenosine triphosphate bioluminescence measuring devices (ATP meters), and ultraviolet (UV) light and gel dot testing points studies have shown that individual housekeeper performance varies unless there is a structured cleaning approach and validated auditing process. (Leas BF, Sullivan N, Han JH, Pegues DA, Kaczmarek JL, Umscheid CA 2015).

At St Vincent’s Hospital Sydney (SVHS) these issues were first examined in 2012 by a multi-disciplinary working party who reviewed the cleaning standards within the hospital. At this time, cleaning services were shared between Ward Services Assistants and Environmental Services and this model proved to have significant short comings. The Environmental Services Department performed all cleaning in occupied rooms, corridors & pan rooms whilst Ward Service Assistants performed the cleaning of patient discharge rooms, central shared areas, sterile stock rooms, kitchenettes, and patient care equipment at the same time as other patient centred duties such as patient transfers, blood product transport and medical record collections. Following an internal review, it was recommended that all cleaning be undertaken by Environmental Services staff.

In August 2013 the Agency for Clinical Innovation (ACI), The Clinical Excellence Commission (CEC) and Bone Marrow Transplant (BMT) Network also commenced a project to improve cleaning standards in BMT units across New South Wales. SVHS joined the project and an initial audit of all 15 BMT units demonstrated suboptimal cleaning.
standards, with no unit reaching the Acceptable Quality Level (AQL) of cleaning. SVHS decided to re-visit the 2012/2013 Cleaning Review to address the increased risk of BMT patients contracting HAIs from sub-standard housekeeping and cleaning.

In February 2014, the Campus Environmental Services Manager, Infection Prevention and Staff Health Services Manager and Executive Sponsors re-evaluated the Cleaning Review and the BMT audit results. As a result, it was decided that Environmental Services would trial a new model of cleaning on the BMT ward Xavier 9 South (X9S) at St Vincent’s Hospital.

The aim of the project was to trial new environmental cleaning practices and initiatives, with the goal of improving patient safety and experiences. These new initiatives included:

- Establishment of a baseline level of environmental cleanliness;
- Identification of methods used to clean units (frequency and process), resourcing, training and education of Environmental Services personnel;
- Matching cleaning start times with ward demands for discharges and patient movements. (All shifts previously started at 6am through to 230pm, leaving no coverage for late discharges or patient moves and transfers);
- Verification of daily work, accountability, monitoring and follow-up with all departments;
- Improvement of relationships within the ward which has been separated in the past between cleaning, patients and nursing that required re-establishment;
- Pilot and validation of an environmental cleaning audit tool against established standards (Victorian Standards in combination with the NSW risk ratings);
- Communication of quality improvements in environmental cleaning standards in BMT / haematology units as an area of extreme risk to all stakeholders.

The new cleaning services model involved restructuring the way cleaning was carried out and audited. The key principles of the model was that it had to be easy to implement sustain, and where possible, cost effective to the organisation. A new cleaning matrix was developed with clearly defined roles and responsibilities, frequency of cleaning and maintenance. A new Cleaning and Hygiene HACCP (Hazard Analysis and Critical Control Point) manual was also developed (adopted from food industry) with supporting policies procedures and safe work practices to ensure staff and patient safety. Additionally, a checklist and sign off book was developed for environmental staff, designed to engage both clinical and non-clinical ward staff and empower a sense of ownership with the Environmental Services Coordinators.

The final stage of the planning for the new cleaning model involved key stakeholders from clinical and non-clinical groups involved allocation of time to conduct audits and review the results. Prior to implementation of the new model all cleaning staff, coordinators and managers were externally trained as accredited auditors using the BMT standards.

Quarterly external independent audits continued using the BMT tool, with significant results of an increased 29% on the first audit at 94%. Note these audits are separate from the BMT program and purely an external audit for the hospitals internal verification.

With the ongoing success of the BMT wards cleanings standards from the point of introduction, it was agreed that in July of 2014 the trial would continue to levels 8 Xavier North and South (8XN/8XS) and Level 7 Xavier North and South (7XN & 7XS). The same success was apparent on both levels with the average external audit score maintained well above the AQL.
### Table of Submissions

**Category: Non-Clinical Service Delivery**

<table>
<thead>
<tr>
<th>Title</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing Advance Care Planning through community engagement</td>
<td>ACT Health</td>
</tr>
<tr>
<td>Advance Care Planning Team, Healthcare Improvement Division</td>
<td>Emma Awizen, Heather McKay, Christine Bowman, Darlene Cox, Anne Knobel, Joy Cocker, Lyn Hunt</td>
</tr>
<tr>
<td>Innovation Working Group – Developing a culture and the</td>
<td>Josephine Chow, Peter Sainsbury, Sue Colley, David Kelly, Marie Tritsaris</td>
</tr>
<tr>
<td>practice of innovation across the organisation</td>
<td></td>
</tr>
<tr>
<td>South Western Sydney Local Health District</td>
<td></td>
</tr>
<tr>
<td>Clinical Innovation and Business Unit</td>
<td></td>
</tr>
<tr>
<td>Upgrading Carbon Cylinders as chlorine water filters for</td>
<td>SLHD</td>
</tr>
<tr>
<td>Renal patients from single tank to twin tanks</td>
<td>Samira Magsudlu, Kesh Chand</td>
</tr>
<tr>
<td>Prevent Alcohol and Risk Related Trauma in Youth</td>
<td>Liverpool Hospital</td>
</tr>
<tr>
<td>(P.A.R.T.Y) Program</td>
<td>Nevenka Francis, Valerie Malka, Scott Damours</td>
</tr>
<tr>
<td>Volunteer Program</td>
<td></td>
</tr>
<tr>
<td>Toronto Private Hospital</td>
<td></td>
</tr>
<tr>
<td>Anne MacLeod, Anna Campbell, Vicki Webber</td>
<td></td>
</tr>
<tr>
<td>A two phase qualitative study to better understand the patient</td>
<td></td>
</tr>
<tr>
<td>experience of Chronic Kidney disease (CKD) and dietary change to</td>
<td></td>
</tr>
<tr>
<td>facilitate change in dietetic services at</td>
<td></td>
</tr>
<tr>
<td>Liverpool Hospital</td>
<td></td>
</tr>
<tr>
<td>Dietetics Department</td>
<td></td>
</tr>
<tr>
<td>Robynne Cooke, Stephanie Notaras, May Mak, Natalie Wilson</td>
<td></td>
</tr>
<tr>
<td>External flammable store (EFS)-Addressing all requirements</td>
<td>Prince of Wales Hospital</td>
</tr>
<tr>
<td>SEALS and Engineering Department</td>
<td>Caroline Hughes, Daniel Trazzera</td>
</tr>
<tr>
<td>A Transdisciplinary Approach To Brain Injury Rehabilitation</td>
<td>Hunter New England Local Health District</td>
</tr>
<tr>
<td>Community and Aged Care Services – Greater Newcastle Sector</td>
<td></td>
</tr>
<tr>
<td>Hunter Brain Injury Service</td>
<td>Christopher Capewich</td>
</tr>
<tr>
<td>St Vincents Hospital Sydney Clean, Reliable, Trustworthy, Proven</td>
<td></td>
</tr>
<tr>
<td>Sustained Excellence in Patient &amp; Resident Care</td>
<td></td>
</tr>
<tr>
<td>The Environmental Cleaning Review &amp; NSW Blood &amp; Bone Marrow</td>
<td></td>
</tr>
<tr>
<td>Transplant Cleaning Project</td>
<td></td>
</tr>
<tr>
<td>St Vincents Public Hospital Syndey</td>
<td></td>
</tr>
<tr>
<td>Environmental ServicesDarlinghurst Campus, St Vincents’s</td>
<td>Rob Gordon, Emily Heinnen, Joanna Uribe, Kirsten Bruchhauser, Kyle Naudi, Michelle Wilson, Giulietta Pontivivo, Brett Gardiner</td>
</tr>
<tr>
<td>Public Hospital level 9 Xavier South BMT ward, level 7 and 8</td>
<td></td>
</tr>
<tr>
<td>Xavier North and South.</td>
<td></td>
</tr>
<tr>
<td>A helping hand - Simple system for best practice and better</td>
<td></td>
</tr>
<tr>
<td>patient outcomes - Development of CACS-GNS Audits and Compliance</td>
<td></td>
</tr>
<tr>
<td>Monitoring Program</td>
<td></td>
</tr>
<tr>
<td>Designing, Implementing and Evaluating a Best Practice</td>
<td></td>
</tr>
<tr>
<td>Peer Work Program for Older People in a Public Mental Health Setting.</td>
<td></td>
</tr>
<tr>
<td>Central Coast Local Health District</td>
<td></td>
</tr>
<tr>
<td>Specialist Mental Health Services for Older People</td>
<td></td>
</tr>
<tr>
<td>Rachel Green, Dominiek Coates, Patrick Livermore</td>
<td></td>
</tr>
<tr>
<td>Good Start to Life – Co-designing optimal maternal and</td>
<td></td>
</tr>
<tr>
<td>infant nutrition resources for and by Maori and Pacific Islands</td>
<td></td>
</tr>
<tr>
<td>Children’s Health Queensland Hospital and Health Service</td>
<td></td>
</tr>
<tr>
<td>Good Start Program, Child and Youth Community Health Service</td>
<td></td>
</tr>
<tr>
<td>Sebastien Brignano, Lasa Sela, Kirstine Kira</td>
<td></td>
</tr>
<tr>
<td>Empowering clinicians: The implementation of a Clinical Audit</td>
<td></td>
</tr>
<tr>
<td>Skills Development Program in Metro South Hospital</td>
<td></td>
</tr>
<tr>
<td>and Health Service</td>
<td></td>
</tr>
<tr>
<td>Clinical Services Excellence Team</td>
<td></td>
</tr>
<tr>
<td>Kylie Sellwood, Lauren Canfell, Kim Gehrke</td>
<td></td>
</tr>
<tr>
<td>Enterprise Content Management System</td>
<td>Spendelove Private Hospital</td>
</tr>
<tr>
<td>'A facility-wide, integrated human resource, accreditation,</td>
<td></td>
</tr>
<tr>
<td>quality improvement, risk management, education &amp; training</td>
<td></td>
</tr>
<tr>
<td>compliance system'Administration (Information Technology Support)</td>
<td></td>
</tr>
<tr>
<td>Effective Provision of Pre-Admission Information to Patients</td>
<td></td>
</tr>
<tr>
<td>by e-mail</td>
<td></td>
</tr>
<tr>
<td>North West Private Hospital</td>
<td></td>
</tr>
<tr>
<td>Emily Lane, Andrea Batt</td>
<td></td>
</tr>
<tr>
<td>Better Practice Program for Mercy Health Home and Community Care</td>
<td></td>
</tr>
<tr>
<td>division</td>
<td></td>
</tr>
<tr>
<td>Mercy Health</td>
<td></td>
</tr>
<tr>
<td>Mercy Health Home and Community Care</td>
<td></td>
</tr>
<tr>
<td>Jane Korneyko, Amanda Bowe</td>
<td></td>
</tr>
<tr>
<td>3-E Model to Develop Capacity, Capability and Culture in</td>
<td></td>
</tr>
<tr>
<td>Improvement</td>
<td></td>
</tr>
<tr>
<td>Fiona Stanley Hospital</td>
<td></td>
</tr>
<tr>
<td>Safety, Quality and Risk; Medical Education</td>
<td></td>
</tr>
<tr>
<td>Catherine Li, Greg Sweetman</td>
<td></td>
</tr>
</tbody>
</table>

---

**The Australian Council on Healthcare Standards**  
**19th Annual ACHS Quality Improvement Awards 2016**  
**Page 31 of 53**
**A. AIM**
To reduce the risk to patients on the Endoscopy Waitlist at Osborne Park Hospital

**B. SUMMARY ABSTRACT**

**Background**
Osborne Park Hospital (OPH) is a secondary Hospital in Perth’s northern suburbs which undertakes low to medium risk obstetrics, rehabilitation and aged care, elective surgery and gastrointestinal endoscopy. The majority of endoscopy procedures performed at OPH are generated by referrals from General Practitioners directly to OPH.

Traditionally patients referred to OPH for endoscopies were triaged according to the elective surgery waitlist categories of Category 1: to be performed <30 days, Category 2: <90 days and Category 3: <365 days. As of 12 January 2014, there were 3,512 patients listed on the OPH Endoscopy waiting list; 2,489 (71%) were over boundary, i.e. patients waiting longer than the recommended wait times per Category.

In early 2014, a Project Officer was appointed at OPH to evaluate and help resolve this protracted waiting list. An audit of the waiting list was conducted by mail. By the time the Project Officer had completed this work, in Dec 2014, there were still more than 3100 cases on the waitlist with 78% of cases over boundary.

With an average of 7 endoscopy lists per week, between 5-7 cases per list, large numbers of referrals and disappointing attendance rates due to late cancellations and failures to attend on the day, it was apparent that a large number of these patients would likely wait years to have their endoscopy at OPH. The OPH clinical leaders became more and more concerned for patient safety.

The OPH approach, built on the “Plan, Do, Study, Act” cycle, utilised valuable lessons learned from the work of the Project Officer. In contrast to the audit phase, OPH self-initiated the development of a multi-faceted project to ensure a consumer-focused, stakeholder-driven project that has subsequently produced sustainable improvements.

**Method**
A multi-disciplinary OPH team, led by the Surgical Services’ Clinical Nurse Manager and supported by the Medical Head of Service identified the multi-faceted quality improvement strategies for implementation in order to tackle the referral, triage and clerical problems.

1. Extended audit of the Waitlist to identify and eliminate cases on the Waitlist that had already been performed elsewhere or were no longer required.
2. The rules for the removal of patients for repeated non-attendance were applied in accordance with the Health Department of Western Australia (HDWA) Operational Directive 0618/15 (Elective Surgery Access and Waiting List Management Policy)
3. The triage categories were reviewed and updated to better reflect the level of OPH’s clinical services, level of patient risk and clinical best practice.
4. A new referral process for General Practitioners (GPs) was developed and implemented so that only referrals that complied with a strict “evidence base” were accepted.
5. Updated, proactive clerical processes were implemented to minimise non-attendance and to ensure the optimal utilisation of the Endoscopy lists, including telephone confirmation in advance of intention to attend.

**Results**
The tables below reflect the impact of the quality improvement strategies on the patients’ Waitlist as well as on the DNA (Did Not Arrive) rate.
Hospital to increase referrals of their Endoscopy patients to OPH, to reduce their waitlist and over boundary cases.

### C. REPORT

#### APPLICATION OF ACHS PRINCIPLES

1. **Consumer Focus**

   Despite disruptions to the OPH Surgical Services on-site because of the construction of new operating theatres (October 2012 – March 2014) as well as staffing restrictions in line with system-wide budgetary constraints, it was an overriding concern for patient safety and acknowledgement of the importance of preventative healthcare measures that provided the momentum for the OPH led Waitlist project after 2014.

   The risks to patients that were addressed included:
   - Patients not being assigned the correct urgency/triage Category.
   - Patients on the Waitlist not being followed up regularly to assess any change in urgency.

   Throughout the project, a patient-centred approach was used.

   Every query, negative feedback and complaint received from patients in relation to the Waitlist was personally dealt with immediately by the Clinical Nurse Manager (CNM) who led the Project, or by the Clinical Nurses in the Endoscopy and Day Procedure Unit. An answering machine was used so that patients could leave messages after hours. During the entire project and up until the date of this submission, there have been no related queries or feedback that have escalated into formal complaints. This is testimony to the patient-centred care approach used by the staff.

   In order to address the DNA (Did Not Arrive) patients, a follow-up process was implemented and monitored closely, with reminder telephone calls to patients prior to their scheduled procedure; patients were gently informed of the policy of two patient cancellations followed by discharge from the waiting list.

   Patients who had been on the Waitlist longest were given priority and their referrals were reviewed and followed up. Two Clinical Nurses were allocated on average 4-8 hours per week (in total) to telephone patients on the Waitlist to ascertain:

   a. If the procedure was still required.

The graph below confirms the reduction of unbooked over boundary patients on the OPH Waitlist.

### Conclusion

The results confirm an effective referral, triage and clerical system that is sustainable. The success of the project confirms the need for patient (consumer) and stakeholder group involvement. Buy-in from Endoscopists and the referring GPs (accessed via the Hospital Liaison GP) was pivotal to the sustained success of this project.

OPH has always focused on prioritising the Category 1 patients and historically there has not been a significant problem related to these patients. By 18 July 2016, it is confidently anticipated that there will be no over boundary Category 2 patients and by 15 August, there will be no over boundary Category 3 patients.

Because of the elimination of over boundary cases at OPH, it is planned for Sir Charles Gairdner Hospital to increase referrals of their Endoscopy patients to OPH, to reduce their waitlist and over boundary cases.
b. If the procedure had been done elsewhere.
c. Whether there had been any significant change in medical acuity or BMI (Body Mass Index) resulting in ineligibility for OPH and necessitating transfer to a tertiary centre.
d. Whether they would be available at short notice for their endoscopy.

If the patient was not contactable their Next of Kin or General Practitioner was contacted to obtain updated contact details, or in the case of the GP, confirmation that the procedure was still required.

If the patient was not contactable, a letter was sent to the patient to explain and inform them of their Waitlist status. In accordance with the Health Department of Western Australia (HDWA) Operational Directive O619/15 (Elective Surgery Access and Waiting List Management Policy) and the patients’ right to be informed and consulted, patients and their referring GP were informed in writing if they were removed from the Waitlist following their second failure to attend. The letter included the date of removal from the waitlist, the reason for removal as well as details of a contact person for enquiries.

The extended Wait List Audit identified 380 patients who were not contactable by telephone and to whom letters were sent. Of these 380, 265 were subsequently removed from the waiting list; in all, a total of 900 patients were removed from the Waitlist. Reasons for the removal of patients from the Waitlist included:

- Procedure had already been completed elsewhere, sometimes as a private patient or sometimes the patient had been waitlisted at more than one hospital initially.
- No longer wished to have procedure, usually because no longer symptomatic.
- Patient no longer lived within the catchment area or nearby.

A major issue the audit identified is that patients do not generally understand the consequences of not attending appointments. Their non-attendance resulted in marked under-utilisation of endoscopy resource and effectively delayed other patients from receiving their endoscopy in a more timely fashion.

The OPH Community Advisory Council (CAC) reviewed and provided feedback to all updated letters to the patients in order to ensure that the information and explanations were appropriately “user friendly”.

2. Effective Leadership
The effectiveness of using existing OPH clinical leaders rather than using a contracted Project Manager underlined the importance of on-site leadership, with buy-in from the staff.

Endoscopy Management Group
This multi-disciplinary group, led by the Surgical Services Medical Head and the Clinical Nurse Manager CNM with medical and nursing clinicians and clerical representatives developed a clear roll-out plan with associated deadlines. Regular meetings were held to monitor progress and ensure that the process was running effectively and to address any difficulties that arose.

The Endoscopy Management Group finalised:
1. The design of a new GP referral form and GP referral guidelines (including rollout plan and website uploads)
2. Education material for GPs regarding the new system.
3. A novel triage system based upon the need for endoscopy or not. Because patients referred to OPH for endoscopies are mainly low to medium risk, a clinical decision was made to extend the Category 1 timeframe from 30 days to 60 days and to remove the Category 2 timeframe completely. This decision was made based on clinical evidence that patient prognoses would not be compromised. Category 2 was eliminated as it was a large stagnant group of low risk cases without clear directives. The updated Categories are as follows:

Category 1 – requires endoscopy as a matter of priority – within 60 days. Endoscopists were encouraged to indicate in writing if they identified elements of the referral that indicated “red flag” status necessitating very early examination e.g. mass on CT scan.

Category 1 requires staged endoscopy – within 12 months. This applies to those cases such as polyp and inflammatory bowel disease follow-up. Endoscopists were encouraged to indicate on the referral precisely when they believe that the endoscopy should be undertaken so that a suitable date is allocated well in advance. Wherever possible, these dates are determined by guidelines.

Return to GP – cases where the symptoms are indeterminate or of brief duration or where the likelihood of significant pathology is negligible.

In these cases, the patients and their GPs are advised that a clinical review rather than an endoscopy is the appropriate step. These patients are not assigned any formal Category
and are not included on a Waitlist. Previously, they would have been assigned category 2 or 3 and would have remained on the Waitlist in excess of 12 months. Using this triage system, these patients should have a clinical review by their GP in 6-12 weeks and be re-referred if their symptoms persist.

4. Education of Endoscopists on the new triage system (including the criteria for returning referrals to the GP).

5. Rules on how long we will keep a referral at OPH (this being 365 days; patients requiring procedures in 2 – 3 years on the basis of guidelines are to be re-referred by GP at that time).

6. Instructions for clerks on booking patients and confirming lists (emphasizing the importance of telephone confirmation rather than relying upon written communication).

7. Creation of appropriately worded letters to go to GPs and patients.

8. Rules for those patients who did not respond to letters and calls (including rules for contacting patient’s GPs).

**Endoscopy Team**

The team consisted of three clerks (booking, admitting and discharge) their Manager, the Endoscopy Clinical Nurse and the CNM as chair. A brief meeting (10 minutes) is held every Tuesday to a specific agenda at which each attendee knows what they need to report. This meeting remains critical to the success of the project.

1. Meeting agenda displayed (this agenda evolved over time)
2. A leader board was written to track progress and for staff to see their achievements
3. Target booking plan set up
4. Waitlist reports of all Category 1 patients not yet booked and past dates assessed
5. Waitlist reports of the longest waitlist for category 2 and 3 also reviewed
6. Reports on number of referrals waitlisted, staged, Category, wrong form, low risk; more info was submitted and recorded so as to assess the compliance in using the new form

Staff involved in the audit were all briefed on using a uniform method of contacting, liaising, documenting and addressing patient concerns and enquiries. Weekly briefing meetings were held to address issues which may arise i.e. patients overseas, awaiting surgery, etc.

GPs were sent individual letters to introduce the new referral form and guidelines, multiple GP newsletter articles were written to draw attention to the new process. GPs in the local area were invited to attend a meeting to discuss the changes and an education event was organised.

3. **Continuous Improvement**

The initial endoscopy waitlist audit that was closed in December 2014 prompted the use of the “Plan Do Study Act” cycle. Many of the improvements designed and implemented by the OPH Project Team emanated from studying the outcomes of the initial audit project and selecting more appropriate and targeted, consumer-focused, stakeholder-involved actions. Some examples are provided below.

**New Referral Process**

A review of the quality of the referral information received from GPs highlighted the need for more detailed, comprehensive information from the GP in order to enable the OPH Gastroenterologists to more effectively triage the patient. The Head of Gastroenterology, Medical Co-Director, Hospital Liaison GP, the Surgical CNM and the Head of Health Information Management Services (HIMS) collaborated to produce a new format referral form in order to obtain the required clinical information from GPs.

**New Referral Form and Guidelines**

The new referral form was developed by an IT company so that it was compatible with the software employed by the six most frequent GP software systems. The new referral form, together with referral guidelines were introduced to the GPs through a mail out to each individual GP and through advertising in GP newsletters. From January 2016 the new referral form was rendered mandatory and, if any other referral forms were used, they were returned to the GP. The new referral form and guidelines were made available on the OPH website already familiar to GPs.

**Letter to GP acknowledging Receipt of Referral**

An acknowledgement letter to the GP to confirm receipt of the referral was developed and implemented. Patients not accepted onto the Waitlist due to not meeting the referral guidelines received a letter as did the referring GP requesting that the patient be reviewed clinically in 6-12 weeks, with instructions to re-refer the patient if the clinical situation had changed.
Increase in Capacity for Endoscopies
Theatre allocation for endoscopies was increased and additional lists made available.

Endoscopy lists were increased from an average of 7 lists per week with an average of 5-7 cases per list in December 2014, to the current level of 10 -12 lists per week, with an average of 6-8 cases per list.

Each endoscopy list is allocated a specific number of points that are calculated based on 1 point for a gastroscopy and 2 points for a colonoscopy. After the intervention it was possible to increase the number of points per list from 12 points to 14 points. The increase in volume was carefully considered in order to maintain procedural quality.

4. Evidence of Outcomes
a. The waitlist audit removed approximately 900 patients who no longer required the procedure but the number of patients on the Waitlist has declined steadily as reflected in the graph below.

b. The number of patients waiting for an endoscopy has been reduced significantly, despite a continuous steady rate of referrals received from GPs.

c. The number of low risk patient referrals returned to the GP for clinical review has declined over time as reflected in the graph below.

d. The number of referrals using the old referral form continues to decrease.

e. Monitoring of complaints from GPs regarding the new system has resulted in fewer than 5 complaints all of which were addressed individually with information on how to download the appropriate form and the clinical safety reasons behind the changes.

f. A survey of GPs regarding the acceptability of the new referral form and new triage method was performed. 102 surveys were distributed by fax after a telephone call to the Practice Manager to recruit their assistance in having the survey completed.

RESULTS: 31 surveys were returned, representing a response rate of 30%. 73% found it easy to use. Those that had difficulty with the form made comments around the fact that there are multiple referral forms for endoscopy around Perth and how much better it would be to have them as a single form, and to have it be able to be electronically submitted. Some complained about the number of questions to be answered, and found it too long to complete.

Ten GPs (38%) had experienced having a referral returned with a request to review the patient after 6-12 weeks. Six of these found this irritating, and made them “angry”. Several GPs still thought that patients with irritable bowel syndrome or non-urgent problems should be placed on an endoscopy waiting list.

In the General Comments section 50% of GPs made comments that they were very happy with the system. One suggested a central referral system of triaging to the shortest waitlist site.

CONCLUSIONS: It is encouraging that the majority of GPs found the new form easy to use.

Several GPs suggested that a universal referral form for all endoscopy sites would be of help, as well as electronic delivery of the form and central referral service triaging to the shortest waitlist. The WA Gastroenterology Advisory Group is currently preparing to do just this with a universal referral form to be sent to the Central Referral System and to be deployed for the whole of WA Health.

Some GPs would like all patients to be put on a waiting list even for non-urgent, low yield cases; there are current national reviews to ensure appropriate and responsible use of endoscopy and many other investigations.

In order to assist the local GPs in adjusting to the new methods a further education event is planned. (Refer to Appendix 5)

g. Assisting with the SCGH waitlist
This project has enabled OPH to assist the SCGH Wait List over-boundary Category 1 patients by increasing the throughput of patients and effectively creating increased capacity at OPH. This has resulted in an additional 10 -15 referrals per week since 24 August 2015. The ongoing reduction in the OPH endoscopy waitlist during this time period underlines the increased efficiency and throughput that the Project’s processes have enabled. OPH will start receiving additional SCGH referrals (aiming for 40 – 50 per week) from 27 June 2016.
5. **Striving for Best Practice**

**Updated Bowel Preparation Information to Patients**

The letter to the patients containing bowel preparation as well as procedural information was updated to ensure clearer information and instructions for patients. This will improve preparation quality and support Endoscopists in achieving best practice procedural results.

**Best Practice Guidelines for GPs**

Patients referred to OPH for endoscopies are not largely “open access”, i.e. not clinically assessed by an Endoscopist prior to their procedure and there is a strong reliance on the GP to provide necessary referral information. Furthermore, all patients’ public sector endoscopy and histology findings are available on an electronic database, which is valuable for accurate cross-checking to ensure that prioritisation is based on accurate information. This overcomes inaccuracies in referral information and also patients changing GPs over time.

Best Practice Guidelines for GPs were therefore critical for improving the OPH Waitlist System.

The triage principles centre around using evidence-based recommendations and guidelines with some general overarching points:

- Symptoms, signs or investigations suggesting a gastrointestinal cancer receive the highest priority.
- An endoscopic examination in the preceding 3-5 years makes the current presence of cancer highly unlikely, even when presentations are due to alarm symptoms e.g. rectal bleeding, dysphagia.
- Colonoscopy yield from previous Osborne Park Hospital audits showed that cancer was found in <2%, almost always in cases with significant alarm features (persistent bleeding, iron deficiency anaemia, faecal occult blood test (FOBT) positive).
- Upper GI cancers are rare and almost exclusively found in >50 yrs. with significant alarm features (dysphagia, iron deficiency anaemia, early satiety AND weight loss).
- Follow-up intervals adhered to national recommendations e.g. Barrett surveillance, colonic surveillance for polyps, post-cancer resection and family history of bowel cancer. However, earlier review was facilitated for specific reasons e.g., inadequate polypectomy, poor bowel preparation.

GP referrals are requested to review “rejected” cases in 6 - 12 weeks to assess for symptom persistence, to
decide if procedures are truly necessary and if they believe that the findings at endoscopy will change management. This is important given the low likelihood of significant pathology in these cases.

**INNOVATION IN PRACTICE AND PROCESS**

**Referral Guidelines for Endoscopy**

Evidence-based guidelines regarding the appropriate cases to refer for endoscopy were developed, circulated to GPs and placed on the OPH website. (Refer to Appendix 4)

**New Referral Form for GPs**

The new OPH endoscopy referral form is being used effectively and has given the Health Department of Western Australia impetus to implement a mandatory standardised referral form.

**Triage process changes**

The three options for triage at OPH were changed to:

**Category 1** – requires endoscopy as a matter of priority – within 60 days. As a result of this triage, these patients will be given a date for their endoscopy. Endoscopists are to indicate in writing if they identify elements of the referral that indicate “red flag” status so that the earliest possible appointment date can be provided.

**Category 3** – requires staged endoscopy – within 12 months. This applies to those cases such as polypl follow-up which require a date but with no urgency. Endoscopists are to indicate on the referral precisely when they believe that the endoscopy should be undertaken so that a suitable date can be assigned well in advance.

**Return to GP** – these are the cases where the symptoms are indeterminate of brief duration or have a low risk of serious pathology. If this “category” is selected, these patients and their GPs will be advised that a clinical review rather than endoscopy is the appropriate step. They will not be assigned any formal Category and will not be added to any waiting list. Previously, they would have been assigned category 2 or 3 and would have languished on the waiting list for well in excess of 12 months. This process will prompt a clinical review in 6-12 weeks and then re-referral if the symptoms have been persisting.

**Gastroenterology triage process was adjusted**

When the Category 1 criteria were met, the patient would be designated appropriate for endoscopy within 60 days. When the referral was for polyp surveillance, a procedural date was advised. When the referral did not meet the minimum standard for needing an endoscopy the referral was returned to the GP requesting a clinical review in 6-12 weeks and re-referral if appropriate.

**Rules regarding wait list management enforced**

All patients who failed to attend an appointment were telephoned by a clinical nurse to determine reason and to rebook if possible. If a patient failed to attend twice, the patient was removed from the list and the GP and patient were informed. Weekly meetings between the CNM and the Administrative Clerks ensured that the staff were supported, their efforts acknowledged and their progress reinforced.

**Endoscopy list organisation**

A point system to more effectively allocate theatre time to Endoscopists was fully implemented. An increased number of cases were booked per list and an increased level of vigilance was applied to the lists to ensure the lists were fully utilised.

**APPLICABILITY TO OTHER SETTINGS**

- Audit of prolonged wait lists has a dramatic impact on the numbers of cases waiting and therefore will impact upon the measures required to tackle a wait list.
- Consistent clerical processes with clear rules, close senior (CNM) supervision and regular feedback and acknowledgement represents a significant component of the success of this project and serves as a model for other services and projects where clerical processes are intimately involved.
- OPH has consulted with the Health Department on the roll out of this form. The form is currently being adapted to be used as the sole State-wide referral form for public open access endoscopy.
- Adherence to clinical guidelines for endoscopy is advantageous to all units with negligible risk of missed pathology.
- Adoption of the triage method as detailed above has patient safety at its core; it eliminates the problem of the deteriorating patient left languishing on a very prolonged wait list and improves access and equity by ensuring appropriate resource allocation.
- The identification of multiple contributing factors to the waitlist problem – referral, triage, booking and communication with stakeholders – and the preparedness to address all elements in seeking a solution is reflected in the dramatic and consistent success of this exercise.
- The reason that this process has had such success rests not only with the new process but also on very strong consistent leadership from...
the OPH Medical Co-Director, Surgical Clinical Nurse Manager, Hospital Liaison GP and Head of Endoscopy. It should not be underestimated how important this energetic, congruent approach is.

- The Western Australian Department of Health is aware of this new process and the success of this initiative has given the WA Health the impetus to try and utilise a more standardised approach to referrals.

### F. REFERENCES

Department of Health, Western Australia. Colonoscopy Services Model of Care. Perth: Health Networks Branch, Department of Health, Western Australia; 2009.


National Institute for Health and Care Excellence (NICE) UK
Suspected cancer: recognition and referral
NICE guidelines [NG12], published date: June 2015
https://www.nice.org.uk/guidance/NG12/chapter/1-Recommendations-organised-by-site-of-cancer#lower-gastrointestinal-tract-cancers

Repeat colonoscopy has a low yield even in symptomatic patients.


Appendix 1: Letter to Patient Regarding Preparation and Procedure Information

Letter to Patient regarding Preparation and Procedure Information (content only)

You have been referred for a Colonoscopy and Gastroscopy. Your procedure is scheduled for an afternoon appointment.

Date:  
Time:  
Place: Endoscopy Suite, Day Procedure Unit, Ground Floor, B Block, Osborne Park Hospital, Osborne Place, Stirling

You will be contacted by Osborne Park Hospital (OPH) up to two weeks prior to your procedure date to confirm your appointment date and time.

Contact OPH as soon as possible on 9346 8490 if you are unable to attend.

If OPH are unable to contact/confirm your appointment date and time with you, your appointment will be allocated to another patient.

Please read ALL of the following Procedure Information herein carefully, and bring this with you to the Hospital on the day.

If you are having this procedure under sedation, please ensure you have someone to collect you from the Hospital and stay with you at home overnight. Failure to do so will result in your procedure being cancelled.

Yours sincerely

Endoscopy Service  
Osborne Park Hospital

Colonoscopy Preparation Using PicoPrep  
Afternoon Appointment

Please read these instructions carefully and contact your GP if you have any queries about the procedure.

Please leave valuables and jewellery at home on the day of the procedure.

---

BOWEL PREPARATION

Please follow these instructions carefully to ensure that your bowel is perfectly clear for the procedure. Failure to do so could result in an incomplete examination and the need to repeat the procedure.

Two packets Sodium Picosulfate (e.g., PicoPrep, Picofax, Picocola) and 3 Bisacodyl tablets can be purchased from your local chemist without a prescription.

Please contact your GP if you have known kidney disease, electrolyte abnormalities or congestive cardiac failure as this preparation type may not be suitable for you.

FOUR DAYS BEFORE YOUR APPOINTMENT

Until you have had your procedure stop eating food with seeds or pits, e.g., multigrain bread, muesli, etc. or fruit and vegetable with skins/peels e.g., tomatoes, sweetcorn, etc.

TWO DAYS BEFORE YOUR APPOINTMENT

You may have breakfast, lunch and dinner today.

Drink as much clear fluid as possible for both days of your preparation as this will assist with cleaning your bowel.

Keep to small servings and omit the following food can be eaten:
- Rice, spaghetti or noodles without sauce
- Rice, pasta
- Nuts
- Olives

Have a glass of any of the following every hour:
- Water
- Sliced tea or coffee
- Apple juice
- Tomato juice
- Cold drink
- Soda water
- Tonic water
- Cordial (not green, blue or red)
Colonscopy Preparation Using Picoprep (Cont’d)

Afternoon Appointment

THE DAY BEFORE YOUR APPOINTMENT

Today you can only ingest clear fluids. Ensure that you drink a glass of clear fluid (as described on the previous page) every hour. Dietary sugar sweetners may be taken, if desired. No food is to be consumed today.

5AM
Take the three Bisacodyl tablets

Taking these tablets will result in several bowel motions after 4 - 6 hours and you may experience transient lower abdominal cramping.

6PM
Take one sachet of Sodium Picosulfate (Picoprep)

1. Dissolve the contents of one sachet of Picoprep in a glass (250mL) of cold water.
2. Drink the contents of the glass over 1-2 minutes, followed by a further 3 glasses (250mL) of water over the next hour.
3. Continue to drink at least one glass of clear fluid per hour.

You will start to have frequent bowel movements soon after taking the preparation and you may experience transient lower abdominal cramping. Discomfort around the anus can be reduced by applying Vaselin to the area.

THE DAY OF YOUR APPOINTMENT

9AM
Take one sachet of Picoprep

Even if bowel movements appear clear it is still necessary to take the second sachet (following the same instructions above) and a further 3 glasses (250mL) of water.

You must not have anything further to drink after 1030AM

Diabetic Patients:

- Monitor your blood sugar level closely.
- DO NOT take your medication but bring it to Hospital.
- Insulin may need to be adjusted before the procedure, please consult with your GP or Specialist Doctor for advice.

Blood Pressure Medication:

- Take blood pressure medication at usual time with a sip of water.

Report to Osborne Park Hospital at your appointed time. You will be ready to go home about five hours later.

Bring:

- Relevant X-rays
- Medicare card
- Information of relevant past medical history and current medications.

Arrange for a responsible adult to accompany you home and remain with you overnight.

Consent Information and Frequently Asked Questions

Your Responsibility:

You may be aware that the wait lists in public hospitals for procedures such as colonoscopy and gastroscopy are considerable. At Osborne Park Hospital, we are making continued efforts to improve our efficiency and reduce the waiting times for these appointments. You can help us achieve our objectives by reading and following the instructions below carefully.

If you are unable or do not wish to attend your scheduled appointment, please ring us immediately on 9365 8690. This enables us to contact the next person on the waitlist.

What is an open access endoscopy procedure?

An open access endoscopy is where the referring doctor, usually a GP, discusses the procedure, risks of the procedure, risks specific to you, sedation, and the risks of not having the procedure. You do not usually see the hospital doctor who is performing the procedure prior to admission. Therefore, it is very important that you read and understand all the patient information before having the procedure. Please contact your GP if you wish to discuss any matters before deciding whether to have the procedure.

Colonoscopy

What is a colonoscopy?

A colonoscopy is where the doctor uses an instrument called a colonoscope to look at the inside lining of your large bowel. This is done to see if there are any growths, polyps, cancers or disease in your bowel.

A colonoscope is a long, thin flexible tube with a small camera and light attached. It allows the doctor to see the pictures of the inside of your bowel on a video screen. The scope bends so the doctor can move it around the curves of your colon. The scope also blows air in your bowel so the doctor can see better. As a result, you might feel some pressure, bloating or cramping during the procedure.

This instrument can also be used to remove or burn polyps and/or take biopsies (small pieces of body tissue for examination and testing). A colon polyp is a growth that forms on the lining of the colon. Although most colon polyps are harmless, some become cancerous over time.

This procedure starts from your back passage (anus) and goes round to the right side of your bowel (cecum). You will be on your side or back while your doctor slowly passes the colonoscope along your large bowel to look at your bowel lining. The lining will be looked at again as the colonoscope is taken out.

You should allow five hours for waiting, preparation and recovery. The procedure itself usually takes between 15 and 60 minutes.

This procedure will require a sedation anesthetic.
Consent Information and Frequently Asked Questions

Will there be any discomfort? Is any anesthetic needed?

The procedure can be uncomfortable and to make the procedure more comfortable a sedative injection or a light anesthetic will be given.

Before all endoscopy procedures begin, an intravenous access is put into a vein in your hand or forearm. This is where the sedation is injected.

What is sedation?

Sedation is the use of drugs to give you a "sleepy" feeling. It makes you feel very relaxed during a procedure that may otherwise be unpleasant or painful.

You may remember some or little about what has occurred during the procedure.

What are the risks of this specific procedure?

There are risks and complications with this procedure. They include but are not limited to the following common, uncommon and rare risks and complications.

Common risks and complications include:

- Mild pain and discomfort in the abdomen for one to five days after procedure. This usually settles with walking and moving around to get rid of the trapped air.
- Nausea and vomiting.
- Headache.
- Pain, redness or bruising at the sedation injection site (usually in the hand or arm).
- Muscle aches and pains.
- Allergy to medications given at the time of the procedure.

Uncommon risks and complications include:

- Approximately 1 in 1,000 may develop a hole (perforation) in the bowel causing leakage of bowel contents into the abdomen. Surgery may be needed to repair the hole.
- Less than 1 in 100 will experience a significant bleed from the bowel where a polyp was removed. Further endoscopy, a blood transfusion or an operation may be necessary.
- Not being able to see the entire bowel. This can happen if your bowel is not completely clean or the colonoscope could not be passed to the end of your large bowel.
- There is a chance of missed polyps, growths or bowel disease.
- Complications of sedation are uncommon but may include difficulty breathing or abnormal heart rhythm.

Preparation for the procedure

The colon must be completely clean for the procedure to be accurate and complete. Follow your instructions carefully, otherwise you may need to have the test again. Please follow the bowel preparation guidelines provided.

What if the doctor finds something wrong?

Your doctor may take a biopsy (a very small piece of the bowel lining) to be examined at Pathology.

Biopsies are frequently taken, even in cases where cancer is not thought to be the problem. They are used to identify many conditions. It is not uncommon for your doctor to find a polyp. If a polyp is found, it may need to be removed in a process called a polypectomy. Samples of the bowel that are removed are sent for pathology testing.
Consent Information and Frequently Asked Questions

What if I don't have the procedure?
Your symptoms may become worse and the doctor will not be able to give you the correct treatment, as they won't know the cause of your problem.

Are there any other tests that I could have instead?
There are a number of tests that can be done to examine the bowel, such as:
- Flexible sigmoidoscopy, however this will only examine the left colon.
- CT Colonography, which is a CT scan which examines the colon.
A colonoscopy may still be required if something abnormal is found.
Your GP should have discussed these options already with you.

What can I expect after this procedure?
You will remain in the recovery area for about two hours until the effect of the sedation wears off.
Your nurse will tell you what you can eat and drink, and you will be given something to eat and drink before you leave.

You might still have some cramping pain or bloating because of the air entering the bowel during the procedure.
This should go away when you pass wind. Moving around helps this.

You will be told what was found during the examination. You will be provided with a written report which will include your follow up arrangements. Follow up is usually with your GP. Should you have any questions, please consult your GP.

What are the safety issues?
Sedation will affect your judgment for about 24 hours. For your own safety and in some cases legally:
- Do not drive any type of car, bike or other vehicle. You must be taken home by a responsible adult.
- Do not operate machinery including a stove or oven.
- Do not make important decisions or sign a legal document.
- Do not drink alcohol, take other mind-altering substances or smoke. They may react with the sedation.
- Do have an adult with you on the night after your procedure.

Notify your nearest Emergency Department straight away if you have:
- Severe ongoing abdominal pain
- Black tarry motions (bowel) or bleeding from the back passage (more than half a cup of blood)
- A fever
- Redness, tenderness, or swelling where you had the injection for sedation for more than 48 hours (either in the head or arm).

Please take your procedure report with you if you are attending the Emergency Department.

Consent Information and Frequently Asked Questions

Gastroscopy

Note: Your stomach must be empty for the procedure to be safe and thorough, so you will not be able to eat or drink anything for at least three hours before the procedure.

What is an open access upper gastrointestinal endoscopy?
An upper gastrointestinal (GI) endoscopy is where the doctor uses an instrument called an endoscope to look at the inside lining of your oesophagus (food pipe), stomach and duodenum (the first part of the small intestine). This is done to look for reasons why you may have swallowing problems, nausea, vomiting, reflux, bleeding, indigestion, abdominal or chest pain.

An endoscope is a long, thin flexible tube with a small camera and light attached which allows the doctor to see pictures of the inside of your gut on a video screen. The scope bends, so that the doctor can move it around the curves of your gut. The scope also knows all into your stomach; this expands the folds of the tissue in your stomach so that the doctor sees the stomach lining better. As a result, you might feel some pressure, bloating or cramping during the procedure.

This instrument can also be used to remove or burn growths or to take tissue biopsies.
To perform the procedure, you lie on your left side and the doctor will pass the endoscope into your mouth and down your oesophagus, stomach and duodenum. Your doctor will examine the lining as the endoscope is taken out.

The endoscope does not cause problems with your breathing.

You should plan on five hours for waiting, preparation and recovery. The procedure itself usually takes anywhere from 10-15 minutes. If the doctor sees anything unusual or wants to test for bacteria in the stomach, they may need to take a biopsy (small piece of tissue) for testing at Pathology.

What are the risks of this specific procedure with sedation?
There are risks and complications with this procedure. They include, but are not limited to the following:

- Nausea and vomiting
- Headache
- Pain, redness or bruising at the sedation injection site (usually in hand or arm)
- Muscle aches and pains
- Allergy to medications given at the time of the procedure.
Consent Information and Frequently Asked Questions

Uncommon side and complications include:
- About 1 in 1,000 will experience bleeding from the oesophagus, stomach or duodenum where a lesion or polyp has been removed. This is usually minor and can be usually stopped with the endoscope.
- Rarely, surgery is needed to stop bleeding.
- Heart and lung problems such as heart attack or vomit in the lungs causing pneumonia.
- Damage to your teeth or jaw due to the presence of instruments in your mouth.
- An existing medical condition that you may have could get worse.
- Emergency treatment may be necessary.

Rare risks and complications include:
- Missed polyp or growth.
- About 1 in 5,000 will accidentally get a perforation (hole) in the oesophagus, stomach or duodenum. This can cause acid of stomach contents into the abdomen. If a hole is made, you will be admitted to hospital for further treatment which may include surgery.
- Your procedure may not be able to be finished due to problems inside your body, or because of technical problems.
- Bacteremia (infection of the blood). This will need antibiotics.
- Death as a result of complications to this procedure is rare.

Notify your nearest Emergency Department straight away if you have:
- Severe ongoing abdominal pain.
- Trouble swallowing.
- A fever.
- Sharp chest or throat pain.
- Redness, tenderness or swelling for more than 48 hours after you had the injection or injection (either hand or arm).

If you attend the Emergency Department, take your procedure report with you.

Notes to talk to your doctor about:


## Appendix 2: New Endoscopy Referral Form (content only)

![Endoscopy Referral Form](image-url)
OPH Endoscopy Guidelines for GPs (content only)

Guidelines for Endoscopy or Colonoscopy Referral by GPs

Who Needs Endoscopy?
High demand for endoscopy services has resulted in prolonged waiting times. Therefore it is crucial to identify those patients that require more urgent procedures.

The following are guidelines to help you identify patients who have a higher likelihood of significant organic pathology and to help reduce the number of unnecessary endoscopy referrals.

General Risk Factors for Serious Pathology:
1. Symptoms that have persisted for 6 or more weeks
2. Patients >60 years of age (and especially >70 years of age)
3. Progressive weight loss and anorexia
4. Fe deficiency anaemia (especially if >60 years of age)

Specific Risk Factors:

a) Colonoscopy
1. Change in bowel habit with alarm symptoms at any age (weight loss, severe pain, anaemia, palpable mass)
2. Patient >60yr reporting rectal bleeding with a change in bowel habit towards looser or increased frequency of stools for 6 weeks or more
3. Patient >60yr with rectal bleeding for >6 weeks and no change in bowel habit or and symptoms
4. Change in bowel habit >6 weeks without alarm symptoms in patient aged >60yr
5. Positive FOBT result (including NBCSP participants)
6. Unexplained iron deficiency anaemia in men or non-menstruating women
7. Abnormal CT/Radion imaging (suspected cancer / large polyp >2cm)
8. Active inflammatory bowel disease or diarrhoea where endoscopy is indicated to progress management

b) Upper GI Endoscopy
1. Chronic GI bleeding
2. Unexplained recent onset persistent dyspepsia in patients aged >55yr in patients aged less than 55 years
3. Dysphagia (interference with the swallowing mechanism that occurs within 5 seconds of having commenced the swallowing process)
4. Unexplained upper abdominal pain and weight loss (>10%) or iron deficiency anaemia
5. Upper abdominal mass
6. Persistent vomiting and weight loss
7. Unexplained weight loss or iron deficiency anaemia
8. Obstructive jaundice (an urgent abdominal USS may be considered)
9. Epigastric mass

Recommended Investigations Prior to Referral:
- Full Blood Count and Iron studies (including Ferritin) in patients with upper and lower GI symptoms will assist in triaging their care.
- A digital rectal examination is essential for any patient with lower bowel symptoms to help exclude a rectal/anal malignancy.
- Stoel NAS in patients with chronic diarrhoea.

Where there is clear-cut concern about the presence of serious GI pathology on the basis of these sorts of symptoms, especially in high risk patient groups, referral for endoscopy is appropriate and OPH will place high priority on attending to these. The risk factors should be clearly stated on the referral to help triage.

However, where there is reasonable clinical uncertainty, especially in lower risk patient groups and in those whose symptoms are of short duration, "it is reasonable to use a period of 'treat, watch and wait' as a method of management" before referring.

In these circumstances, arranging for a clinical review in your rooms in 6 - 8 weeks is the more appropriate first step. If clinical concern remains after this review, referral for endoscopy is then appropriate.

*as per the NICE guidelines (http://www.nice.org.uk/guidance/cg92/chapter/2-guidance/upper-gastrointestinal-cancer)
Surveillance for Bowel Cancer Screening Guidelines

1. Average risk
   No close family history of bowel cancer.
   
   **Screening recommendation:** FOB testing alternate years from age 50.

2. Slightly above average risk
   One first degree relative diagnosed age >55.
   
   **Screening recommendation:** Same as for the average-risk population. Currently no indication for colonoscopy unless alarm symptoms present. Alternate year FOB testing from age 50.

3. Moderately increased risk
   First degree relative diagnosed age <55.
   Or two first degree; or one first degree and one second degree relative(s) on the same side of the family with bowel cancer diagnosed at any age.
   
   **Screening recommendation:** Refer for colonoscopy at five yearly intervals starting at age 50, or 10 years younger than the age of the earliest diagnosis of Colorectal Cancer in the family, whichever comes first.

4. High risk (50% or higher risk of cancer)
   Hereditary Non-Polyposis Colorectal Cancer (HNPCC) family members, Familial Adenomatous Polyposis.
   
   Suspicion of a high-risk syndrome should be raised when two or more close relatives are affected; Colorectal Cancer has been diagnosed at an early age (the earlier the age, the higher the degree of suspicion), or certain syndrome-specific characteristics are present.
   
   **Screening recommendation:** Will probably require colonoscopy annually beginning at age 25 or 10 years younger than earliest age of diagnosis of Colorectal Cancer.
   
   Will require genetic assessment.
   
   Please refer patient to a specialist centre for surveillance decisions.

*NH&MRC Guidelines for colonoscopy 2005
Digestive Health Network Colonoscopy services modal of care 2007*
Appendix 5a: GP Survey Report

**GP Survey Report**

**BACKGROUND**
In 2015 a multifaceted approach was instituted at Osborne Park Hospital in order to improve patient access to gastroenterology endoscopy. This included auditing of the very long wait list, the design and institution of a new endoscopy referral form for GPs and development of guidelines for GP referral. In addition, GP referrals that did not comply with the guidelines for endoscopic investigation were returned to the GP with a letter to the GP and patient suggesting a clinical review in 6-12 weeks.

A survey was administered to gauge the response of GPs to these changes.

**METHOD**
A survey was faxed to 102 GPs who had referred patients to OPH for endoscopy in the preceding 6 months (see Appendix 5b).

A nurse telephoned the practice manager at each of the practices to recruit their assistance in having the survey completed.

31 surveys were returned. A response rate of 30%.

**RESULTS** (see Appendix 5c)
- 17 GPs recalled receiving the information regarding the new process (55%)
- 45% had experience of using the new referral form
- Of those that had experience of using the form, 73% found it easy to use. Those that had difficulty with the form made comments around the fact that there are multiple referral forms for endoscopy around Perth and how much better it would be to have them as a single form, and to have it be able to be electronically submitted. Some complained about the number of questions to be answered, and found it too long to complete
- 10 GPs (38%) had had a referral returned with a request to review the patient after 6-12 weeks.
  - 6 of these found this irritating, and made them “angry”, several still thought that patients with irritable bowel syndrome or non urgent problems should be placed on a waiting list.

In the general comments section 50% of the GPs that made comments, were very happy with the system. One suggested a Central Referral System (CRS) of triaging to the shortest waitlist site.

**CONCLUSIONS**
It is encouraging that the majority of GPs found the new form easy to use. Several GPs suggested that a universal referral form for all endoscopy sites would be of help, as well as electronic delivery of the form and CRS triaging to the shortest waitlist. The WA Gastroenterology Advisory Group is currently preparing to do just this with a universal referral form to be sent to CRS.

There were comments suggesting that the GPs would like all patients to be put on a waiting list even if that is very long for non-urgent problems. This may demonstrate that more education is required to inform GPs of the best use of this investigation.

Two months into this project, local GPs were invited to attend an information seminar on the new referral methods. There was a low turnout to this event, but those GPs that attended seemed satisfied and better informed. In order to assist the local GPs in adjusting to the new methods a further education event is planned.
Appendix 5b: GP Survey Tool

GP Survey Tool

GP Survey - New referral Process for Endoscopy at OPH

In order to tackle the enormous wait list of over 3000 patients waiting for endoscopy at OPH a project was commenced in Jan 2015. This project involved:

- Development of a new referral form to provide improved data to allow more accurate patient triage;
- Endoscopy Guidelines published on the Hospital website;
- All referrals not fitting the guidelines for endoscopy were returned to the GP for the patient to have a clinical review in 6-12 weeks, instead of being placed on a very long wait list.

As a consequence of this project and other interventions, the waitlist is now under 1000 and the chances of patients that require endoscopy getting it in a timely manner are markedly improved.

SURVEY

We are interested in improving this model of care. Please can you complete this short survey as your opinion is important to us?

1. Do you recall being sent information regarding this new process?
   - Yes ☐ No ☐

2. Have you had experience of using the new referral form?
   - Yes ☐ No ☐

   If so did you find it easy to use?
   - Yes ☐ No ☐

Are there any improvements that could be made?

3. Have you had experience of having a referral returned with a request for clinical review?
   - Yes ☐ No ☐

   If so how did you feel about it?

4. Do you have any suggestions regarding how to improve this process?

5. Any further comments on how we can improve the referral process

_____________________________________________________________________________
### GP Endoscopy Survey

#### Raw Results and Comments

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you recall being sent information regarding this new process?</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>7. a. Have you had experience of using the new referral form?</td>
<td>28</td>
<td>6</td>
</tr>
<tr>
<td>7. b. If so did you find it easy to use?</td>
<td>28</td>
<td>8</td>
</tr>
<tr>
<td>7. c. Of those who had experience of forms, easy to use?</td>
<td>19/28</td>
<td>6/28</td>
</tr>
<tr>
<td>8. Have you had experience of having a referral returned with a reason for clinical review?</td>
<td>10</td>
<td>18</td>
</tr>
</tbody>
</table>

#### Comments:

- Are there any improvements that could be made to the referral form?
  - Get rid of it.
  - The referral form has too many questions; I would rather just write out reason for referral.
  - Please synchronize with other AHS providers - i.e., use the same form, currently different templates for each.
  - Best practice form vary "hifi" and repetitive to complete, lots of tick boxes. Maybe a split form better.
  - Could you facilitate outlining for non-urgent referrals e.g., USS screening. If patients are listed on CPHN why do they still get letters from DHH?
  - Takes too long.
  - Schedules to refer to chain box is a little cryptic.
  - Patient demographics will not filter into the referral form.
  - New form a bit tedious compared to previous form.
  - In best practice a larger area for medication list.
  - No happy with it.
  - The referral form is too busy visually.

---

### How did you feel about having a referral returned?

- didn't like
- It was returned asking for histology results for a colonoscopy done at CHAP, CHAP should check their records of past scope histology.
- Irritating
- Very angry, the reason the waiting list is now 300 and not 300 is because no one is referring because of your process.
- Get rid of it.
- Gate keeper
- I think it is OK but wait listing for urgent referrals i.e., no less deficiency is still too long.
- Could perhaps streamline non-urgent referrals by adding indicator based symptoms to form.
- Please triage and place patients on the waiting list instead. GPs refer patients that need further investigations. Do not treat our referrals as being indolent/invasive or not being necessary.
- I think you do an amazing job in a difficult/demanding situation.
- If I feel the patient definitely needs a scope I will refer elsewhere.
- Fair enough.
- It should be read and not sent back inappropriately. I'd check the criteria and the patient did fit. A new appointment was required and it delayed care.
- Happy to see patient to review symptoms if clinically appropriate and no red flags.

---

Any further comments on how we can improve the referral process:

- Go back to the old way.
- Great program.
- Please enable submission of referral by MD exchange, triage to the shortest waitlist location.
- Need MD template uniform for all AHS providers.
- Most patients very pleased with CHAP endoscopy.
- Seems pretty straightforward.
- Patients always bothering us as to why the wait is so long.
- Current system seems OK.
- Fine if it improves access.
- It was upsetting to have the referrals returned when they were not on the correct form as we had difficulty sending in the new forms.
- Need a better referral form that is easier to use (had trouble with demographics entering onto form automatically).
- I had a lot of letters about old referrals asking if they still need to be on list some had only been referred 3-4 months earlier and others were recalled recommended by CHAP endoscopy. This was frustrating.
- Run more endoscopy clinics or faise with radiology re CT colonography.
- State specific reasoning for GP referral.
- It would be great to have a point of contact with whom to discuss referrals - would possibly reduce the number of inappropriate referrals.
Prince of Wales Hospital
Emergency Department

ED Navigator: impact and evaluation of ED performance of an extended service model
Wayne Varndell, Elizabeth Ryan

A. AIM
The aim of this trial was to evaluate the impact of an extended Nurse Navigator model of care on patient flow in a metropolitan ED.

B. SUMMARY ABSTRACT
Emergency care is complex, with patients' physiological tolerances and degrees of incapacitation highly variable between each case and necessitating differing levels of ED resources. As the number of patients presenting to ED exceed departmental operational capacity (College of Emergency Nursing Australasia 2016), undifferentiated patients waiting assessment and intervention are delayed for extended periods of time. Further, as inpatient capacity is reached, admitted patients in ED become blocked; a situation which exacerbates ED overcrowding (Richardson 2002). ED overcrowding and access block are an international issue, and are associated with increases in patient morbidity and mortality, and increases in staff stress (Fatovich, Nagree & Sprimulis 2005; Richardson & Mountain 2009; Richardson 2006). One key reason for the development of ED overcrowding is poor patient flow and communication, specifically, the flow of admitted patients in ED and inpatient team (medical and nursing) communication (Varndell et al. 2016).

Historically, ED models of care have been forward facing, with the focus on early assessment and discharging of patients (NSW Ministry of Health 2012). Few models of care have focused on optimising admitted patient flow and inpatient team communication. One such model of care that has been implemented at Prince of Wales ED is the ED Nurse Navigator. The role of the ED Navigator is to enhance the patient’s journey through the department in a timely and safe manner, by utilising departmental resources optimally, improving team collaboration and enhancing patient flow (Emergency Care Institute 2013).

Originally implemented as an 8 hours a day, 5 days a week service (group 1), the aim of this project was to evaluate the impact of expanding the ED Nurse Navigator model of care to 16 hours per day, 7 seven days a week (group 2). This quality improvement project was conducted between August 3rd and October 4th. The ED Nurse Navigator role was staffed by senior emergency nurses familiar with the Department and inpatient teams. The nurse navigator provided clinical leadership to nursing, medical and allied health staff to enhance the patient's journey through the ED. Through this role and familiarity with the way the ED works operationally, nurse navigators guided and supported staff in delivering appropriate patient care. Additionally, nurse navigators actively identified potential admissions or direct admissions and coordinated the transfer of the patient to the ward in a timely manner. Working collaboratively with the patient, relatives, inpatient teams and ward nurses further identified areas for future change while improving communication and understanding resulted in improved patient flow.

By expanding the ED Nurse Navigator model of care, usage and associated costs ($24,039) of the ambulance release team decreased, improved patient flow (Transfer of Care 81.9% vs. 94.1%; p=.041), increased Emergency Treatment Performance (EPT) achievement (21% vs. 47%; p=.03), decreased patient length of stay (admitted, 6.7h vs. 6.1h; p=.06 and discharged, 3h vs. 2.5h; p=.057), and shortened decision to admit times (2.9h vs. 1.2h; p=.029). As a result of the improved departmental and organisational performance associated with expanding the ED Nurse Navigator model of care, the recommendation to indefinitely sustain the expanded service was approved.

REFERENCES
Emergency-Department-Overcrowding-and-Access-Block.pdf>


### Category: Healthcare Measurement

#### Table of Submissions

<table>
<thead>
<tr>
<th>Title</th>
<th>Authors/Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing hospital length of stay while improving functional outcomes for patients admitted to the rehabilitation unit at Calvary Hospital in the ACT</td>
<td>Jennifer Azurin, Caroline Fargher</td>
</tr>
<tr>
<td>Statistical Thinking and Methods: Deming’s System of Profound Knowledge = Science of Improvement.</td>
<td>Helen Ganley, Janine Carragher, Angie Pang, Victoria Walton</td>
</tr>
<tr>
<td>Let’s Wed and See – Promoting Optimisation of Antimicrobials via the Marriage of GuidanceMS and the eMMS Prescribing System</td>
<td>Julie Mansy, Lucy Lin, Ross Vergios, Joanne Rimington</td>
</tr>
<tr>
<td>ED Navigator: impact and evaluation of ED performance of an extended service model</td>
<td>Wayne Varndell, Elizabeth Ryan</td>
</tr>
<tr>
<td>A multidisciplinary Clinical Documentation Improvement Program resulting in improved patient safety and enhanced clinical engagement.</td>
<td>Nicole Draper, amantha Ryan, Matthew Dwyer</td>
</tr>
<tr>
<td>An Electronic Tool for the Management of Safety and Quality Data ‘Reporting Ward to Board’.</td>
<td>Stephen West, Gayle Frohloff, Anne Morton, Daniel Prentice, Karen Kasper</td>
</tr>
<tr>
<td>Reducing time to antibiotics in suspected sepsis</td>
<td>Rohan Laging</td>
</tr>
<tr>
<td>Sustaining Improvement in the management of the Endoscopy Waitlist</td>
<td>Anne MacDonald, Clare Matthews, Michael Levitt, Hooi Ee, Dev Sagarajisingam</td>
</tr>
<tr>
<td>Reaching the Pinnacle of Hospital Management through Business Intelligence (BI), Balanced Scorecard, KPIs, SOPs and Strategic Cost Management-The Hemas Hospitals Story</td>
<td>Portia Jayamaha, Chandima Cooray, Hiran Perera, Dinupa Peris, Niroshan Ashokumar, Supun Fernando, Ishantha Tennekoon, Chathuranga Sampath, Sangiah Saravanacanth</td>
</tr>
<tr>
<td>The Implementation and Evaluation of Universal Decolonisation in an Australian Quaternary Intensive Care Unit</td>
<td>Jodie Dawkins</td>
</tr>
</tbody>
</table>