Quality Initiatives

Entries in the 17th Annual ACHS Quality Improvement Awards 2014.

Published by:

The Australian Council on Healthcare Standards (ACHS)
November 2014

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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
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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 2014, the 17th Annual ACHS QI Awards were open to submissions from all ACHS 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.

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.
- **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 consumer / 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 EQuIP 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.

In 2013, the 16th Annual ACHS QI Awards had 104 submitted entries with 54% in the Clinical Excellence and Patient Safety category, 27% in the Non-Clinical Service Delivery category and 19% in the Healthcare Measurement category.
The 17th Annual ACHS QI Awards 2014

Winner Submissions

Clinical Excellence and Patient Safety
Central Coast Local Health District
Children and Young People’s Mental Health (CYPMH)
The Keep Them Safe Whole Family Team Gosford Pilot Project
Deborah Howe, Dominiek Coates & Belinda Hodges
Full Report page 5

Non-Clinical Service Delivery
Country Health South Australia Local Health Network
Safety and Quality Unit
BloodMove Project
Merrilee Clarke & Rick Tocchetti
Full Report page 23

Healthcare Measurement
Melbourne Health
Influenza Vaccination Working Party
Taking staff influenza vaccination rates to a record level
Peter Bradford, Nicky Webster, Kathryn Williams & Irene Salkunas
Full Report page 38

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

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).
## Clinical Excellence and Patient Safety

- **Western Sydney Local Health District**
- **Blacktown Community Mental Health Services**

  Community assessment and acute home treatment for people with mental illness – an evidence based model of care
  
  *Paul O’Halloran, Ashley Baker, Vera Labuzin & Donna Gillies*
  
  Summary Report page 13

- **Hunter New England Local Health District**
- **Children, Young People and Families**

  “Going MAD in the ED”
  
  Improving pain management for children in rural emergency departments by targeted introduction of intranasal Fentanyl
  
  *Helen Stevens, Elizabeth Cotterell & Anne Sivell*
  
  Summary Report page 16

## Non-Clinical Service Delivery

- **Hunter New England Local Health District**
- **Mehi/McIntyre Mental Health Service**

  The Rural/Remote Recruiting and Retention Value-Based Redesign (R5) Project: Improving Consumer Outcomes Through Values-Based Human Resource Processes
  
  *Leigh Philpott, Melissa Scott, Dottie LeRoux & Shannon McNamara*
  
  Summary Report page 29

- **Austin Health**
- **Specialist Clinics Projects Team**

  Patient self check in for Specialist clinics in the outpatient setting
  
  *Monica Finnigan, Sophie Karamazalis & Melinda Cosgriff*
  
  Summary Report page 31

- **Queen Elizabeth Hospital, Hong Kong**
- **Supporting Services Department, Administrative Services Division**

  To Enhance Occupational Safety and Health (OSH) Knowledge of Frontline Supporting Staff through Interactive Competence Training
  
  *Elaine Ng*
  
  Summary Report page 33

## Healthcare Measurement

- **Monash Health**
- **Monash Health Patient Flow and Dandenong Hospital Orthopaedics and Operations teams**

  Patient-centred innovation in orthopaedic patient pathways
  
  *Brydie Quinn, Ton Tran & Jane Poxon*
  
  Summary Report page 45
A. AIM
The central aim of the KTS-WFT pilot project is to address the needs of whole families and increase family safety and functioning for families with parental mental health and/or drug and alcohol problems where there are child protection concerns.

B. ABSTRACT
Children in families where there are high levels of child protection risk are not only at risk now but are also at risk in the future in terms of very well documented second generation cycles of child abuse and neglect, mental illness and drug and alcohol abuse. In 2007 the New South Wales (NSW) Government commissioned the Special Commission of Inquiry into Child Protection Services in NSW (Wood, 2008). The Special Commission of Inquiry found that carer substance use and mental health issues are significant factors in child protection reports and in decisions taken on the need for statutory intervention. In response to this, and in an effort to make children safer in their families, the Keep Them Safe-Whole Family Team (KTS-WFT) Pilot was established and implemented as one of a suite of initiatives being implemented under Keep Them Safe: A shared approach to child wellbeing (KTS). KTS is the NSW Government’s five-year plan to fundamentally change the way children and families are supported and protected, with the aim of improving the safety and wellbeing of all children and young people in NSW.

KTS-WFT Gosford pilot is under the governance of Children and Young People’s Mental Health (CYPMH), Central Coast Local Health District (CCLHD), and is one of four pilots in NSW. The KTS-WFT Gosford is a tertiary health service targeted at families where there are parental mental health (MH), drug and alcohol (D&A) and child protection concerns.

Research consistently highlights mental illness and substance abuse to impact negatively on parenting capacity (Fernandez, 2007). While many parents with mental health illness are able to cope well with parenting and some children show little, if any, adverse outcomes, there is a strong association between parental mental illness and/or alcohol and drug use and poor outcomes in children (Falkov and Lindsay, 2002). Positive change in these domains is consistently found to be positively related to improvements in children’s mental health (Webster-Stratton et al., 2004). To achieve positive change in these domains, MH and D&A workers work together in a multidisciplinary team, taking family referrals primarily from Community Services (CS) where there is a risk of significant harm, mental health and/or drug and alcohol problems. The service is unique and provides an outreach service to the whole family, providing comprehensive assessment, and a range of individual and family interventions for a period of six months. KTS-WFT clinicians help to reduce the risk of child protection concerns, increase parenting skills and help clients with their mental health and/or drug and alcohol problems. Interventions offered can be best understood in an early intervention model of practice which includes in the short and medium term the building of resilience in children and the increase in parental competence through the application of parent skill training.

Thus far the KTS-WFT Gosford has been a great success. Over a three year period (since its outset in April 2011 until the 31st of March 2014), the KTS-WFT Gosford has worked with 193 families, consisting of 700 individuals. An internal evaluation conducted by CYPMH of the KTS-WFT Gosford and an external evaluation of the four pilot sites show positive outcomes for the participating families and indicates that the KTS-WFT Gosford pilot has made a significant contribution in that it makes families in which children reside safer places to be.
C. APPLICATION OF ACHS PRINCIPLES

1. Consumer Focus
A core concept of the KTS-WFT project is that the KTS-WFT treatment teams and CS workers collaborate with families towards the goals of family health and a safe environment for children. Interventions are tailored to the needs of each family, as well as individuals within the family to ensure the intervention addresses the multiple and complex needs effectively. Goals are identified together with the family to make sure goals are achievable and meet the needs of the family as well as the referring agency.

To our knowledge, there is no other service model that looks at the needs of all individuals in the family. While most services focus on an individual within the family, all individuals in the family accepted by the KTS-WFT Gosford have a care plan. Given the complex needs of the families referred to the KTS-WFT, interventions are flexible and designed through consultation with CS as well as the family.

Furthermore, given that this is a pilot project, our ongoing experience working with the families referred to the KTS-WFT Gosford has informed the evolution of the service model. Ongoing service improvement is ensured through daily critical reflection and client consultation as well as a more structured evaluation that captured the clients’ voice.

To ensure client experiences and feedback informs the ongoing development of this pilot project, interviews are conducted with families that have completed the WFT intervention. As outlined in the next section, as part of the internal evaluation of the KTS-WFT, families receive a phone call from the CYPMH Research Officer after discharge and are invited to participate in an interview pertaining to their experiences working with the WFT. Thus far, the feedback of these interviews is overwhelmingly positive and has informed service improvement.

The development and evolution of the model is also informed by the consumers’ voice as documented in the existing literature.

2. Effective Leadership
The KTS-WFT Pilot has been implemented in four regional and rural sites across New South Wales: Lismore, Newcastle, Gosford, and Nowra. As noted, the Gosford pilot is under the governance of CYPMH, CCLHD.

In 2010, following a competitive tender process, CCLHD received dual funding from the NSW Department of Premier and Cabinet for the implementation of the KTS-WFT Gosford, with a 66% component nominated as MH and 34% as D&A. For the Gosford project, the decision was made that an integrated team would be formed with the funding streams merged. This decision was informed by the intent of the State Model of Care framework and the statistical prevalence of co-morbidity in the target populations. The D&A and MH components of the Gosford KTS-WFT are integrated into one team, under one accountability line, under the governance of CYPMH.

Leadership is provided by a state-wide steering committee as well as a local steering committee both of which the CYPMH service manager is a member. A Gosford KTS-WFT Steering Committee was established with representation from D&A, MH and child protection services on the Central Coast to provide advice to the WFT project development and Model of Care (MoC), participate in recruitment of all staff and support cross service integration and collaboration.

Leadership to the Gosford KTS-WFT team is provided by the WFT team leader, the CYPMH non-acute service manager, the CYPMH service manager and the Manager for D&A services who come together in a whole family management meeting. The lessons learned at KTS-WFT Gosford continuously inform service improvement locally as well as service development at a State level.

Effective leadership has been essential to the success of this pilot project. Effective leadership has ensured the development of strong collaborative partnerships and the implementation of a highly and diversely skilled multidisciplinary team.

The development of strong collaborative partnerships has been essential to the success of this pilot. The central theme of the KTS is that care and protection for children and young people is a shared responsibility between families, communities, government and non-government organisations that work together to support and protect vulnerable children. This new service model addresses the need for collaborative partnerships to stop families falling between the gaps. It was recognised during the design of the program that the KTS-WFTs would not be able to address all mental health and alcohol and other drug problems, or to provide all the clinical and
other support services required by the families. It was anticipated that families potentially would be involved with a number of support agencies upon referral to WFTs.

Families who are referred to the WFTs have complex and multifactorial needs, requiring a high degree of service support and integration. Because of this, the WFTs have worked closely with other support services and agencies to ensure that client service needs are met. In particular our partnership with CS has been a critical factor in the successful implementation of the WFT. Gosford KTS-WFT and CS have worked to build trust, maintain transparency and respect for boundaries between each other and with the client families. We have worked hard to develop a culture around shared decision making around child protection issues with CS. To facilitate open communication and collaboration we have developed a number of formalised processes with CS.

In addition to our partnership with CS, strong leadership has ensured the development of a range of strong partnerships with other health agencies, schools, private specialists, paediatricians, GPs, other government services such as housing NSW, a range of NGOs, drug and alcohol services and more. Each of these partnerships has informed the success of this pilot. Our willingness to work towards a shared goal, a strong level of mutual trust and commitment at the executive level, and joint responsibility for directions and activities related to the partnership have been vital to the success of this pilot project.

Strong leadership has also seen the recruitment and establishment of a multidisciplinary team of Mental Health and Drug and Alcohol workers who work together with the support of a Child and Adolescent Psychiatrist. The team consist of clinicians with skills from a diversity of backgrounds, including alcohol and drug, sexual assault, mental health, child protection, and NSW Housing; this diversity of experience and skills is essential in addressing the complex, multiple and diverse needs of the families referred to the KTS-WFT Gosford. The voice of each clinician has informed the ongoing development of the service model. In addition to being consulted in regard to service improvement and development, clinicians were given the opportunity to participate in confidential in-depth interviews as part of the internal evaluation of the KTS-WFT Gosford. (This is outlined under section 4).

3. Continuous Improvement
The ongoing evolution of the model has been informed by regular consultations with a range of stakeholders, including referring agencies (community services, mental health and drug and alcohol) health managers, and clinicians. Furthermore, the development and evolution of the model is also informed by the consumers’ voice through interviews, regular informal consultation and as documented in the existing literature. Ongoing service evaluation is central to improving service delivery and sustaining quality models of care and this is primary to our practice.

The service model for the KTS-WFT Gosford has evolved since the commencement of the pilot. The model of care is adaptive and flexible in response to the mix of disciplines and skills within the WFT, and the presenting needs of families.

For example, while initially the team was staffed with clinicians from a range of backgrounds and disciplines, a ‘Family Support Worker’ position was created in 2013 in response to the needs of the client group and feedback from staff. The Family Support Worker position was created to support the clinical team by dealing with psychosocial stressors for families such as housing. The Family Support Worker works alongside clinicians to address practical barriers to therapeutic interventions that are common for this high risk client group. This allows clinical workers to continue to focus on the individual care plans of family members.

Furthermore, the service model has also evolved to a co case management model in the sense that multiple clinicians are allocated to each family based on experience, skills and discipline. For example, while the clinicians most experienced in drug and alcohol interventions works with the parent with drug and alcohol concerns, a clinician most experienced in mental health interventions works with the parent with mental health issues and another clinician works with the children depending on need. There is evidence in the literature that a co case management model enables a focus on the child as well as parent and that this approach enables increased input of skills and interventions into that family. The change to a co-case management approach has also been a major contributor to improving staff wellbeing and protecting WFT clinicians against burnout.

In addition, ongoing service improvement is facilitated by an in-depth and ongoing evaluation of the service model by CYPMH as outlined below.
4. Evidence of Outcomes

Over a three year period (since its outset in April 2011 until the 31st of March 2014), the KTS-WFT Gosford has worked with 193 families, consisting of 700 individuals. Both an internal and external evaluation of the pilot show positive outcomes for these families and individuals.

An external evaluation was conducted by Urbis. This evaluation is not specific to WFT Gosford but incorporates an evaluation of the other three pilot sites as well. The external evaluation of the KTS-WFT four pilot sites and an internal evaluation of the KTS-WFT Gosford show positive outcomes for the participating families.

An internal evaluation conducted by the CYPMH research officer also shows positive outcomes, and put forward a number of recommendations for service development which have been implemented.

The ongoing effectiveness of the WFT is measured through pre and post intervention changes in the North Carolina Family Assessment Tool (NCFAS) (which is a tool designed to measure the effectiveness of intensive family preservation interventions), interviews with clients about their experiences with the service and their views on how the service has impacted on their parenting and family functioning, as well as in-depth interviews with all the WFT clinicians and management.

Ethics approval for this evaluation was received by the Northern Sydney Local Health District (NSLHD) Human Research Ethics Committee and the Research Manager, Central Coast Local Health District (see appendix 4).

Interviews with Discharged Clients

All clients who complete the WFT program are invited to participate in ‘post discharge’ interviews. All families discharged before 2014 (112) were posted an information statement and consent form inviting them to participate in a telephone interview. Twenty people participated in the interviews, of which 18 were very complimentary of the service they received making comments such as:

- It gave me solutions. It helped me think about my parenting (Kristy)
- It was good to talk to someone, and they actually did listen. That was really good. (Annie)

One individual explained that she did not have a positive experience with the WFT, and that she did not really engage with the service. Her child was removed by CS. The remaining person appeared quite unwell and did not appear to recall her involvement with the WFT.

Analysis of Outcome Measures: North Carolina Family Assessment Tool (NCFAS)

Clinicians routinely complete a measure called the North Carolina Family Assessment Tool (NCFAS). Clinicians complete this measure three times, firstly within 6 weeks of working with the family, secondly at 13 weeks of intervention and lastly at discharge.

The NCFAS was developed in the USA for use in intensive family preservation services. It contextualises issues such as mental illness and substance misuse in the impact they have on the family, especially the children, as well as considering the social determinants of health. In the KTS-WFT context it has utility in guiding assessment and treatment planning as well as measuring outcomes.

The NCFAS measures family functioning from the perspective of the worker most involved with the family. The tool includes 8 domains that look at the family as a whole in terms of environment, parental capabilities, family interactions, family safety, child well-being, social/community life, self-sufficiency, and family health. These domains include a total of 58 subscales.
Pre and post intervention data from the NCFAS is used to evaluate where families have made progress, the number and percent of families with negative change or moderate/serious problems remaining at case closure, and evaluate which closure ratings are consistently low for which domains and which have made significant progress. As shown in table 1 and 2 in appendix 3, participating families have made significant positive change between commencement of the intervention and discharge.

The NCFAS data was also analysed in SPSS, to test the NCFAS subscale items to see where the most significant changes were made between intake (59 completed measures) and discharge (60 completed measures).

A one-way ANOVA tests was conducted for the individual NCFAS items.

This data shows that the KTS-WFT Gosford intervention makes a substantial positive impact across a broad range of family functioning and parenting outcomes. As shown in table 3 in appendix 3, a statistically significant improvement between intake and discharge occurred on the majority of the 58 subscale items (32/58). The lack of changes on other items is mostly due to floor effect. On intake few clients scored on this item and so there was little room for change.

Interviews with clinicians and management
All WFT clinicians and management participated in a semi-structured 1 hour interviews with the research officer. Participation was voluntary and efforts will be made to ensure confidentiality.

Questions focussed on descriptions of the client group, and, the experience of the worker, including which types of interventions are most effective when working with the WFT families. In addition, questions were asked regarding the impact of working with these families on the worker, and how these impacts are managed.

Analysis of these interviews shows that the clinicians and management are highly supportive of the WFT model, and feel confident that the positive impacts on the families through the WFT intervention are extensive. Analysis of the interviews has generated a number of recommendations for service improvement which have been implemented.

External/independent evaluation by Urbis
The evaluation findings reported by Urbis are consistent with, and compliment, the findings of the internal evaluation. This evaluation draws on several sources of information including:

- Pilot site data and reporting including clinical data
- Community Services data on children referred to WFT
- 50 stakeholder interviews conducted between June and August 2013
- 25 client surveys and 12 client interviews
- Detailed case studies of fifteen families who have been clients of WFT
- Economic analysis based on data from the case studies.

This evaluation has found evidence indicating that, for participating families, the KTS-WFT Pilot has led to a significant improvement in adult mental health outcomes, reduced rates of ROSH (risk of significant harm) reports for participating children, reduced reported rates of parental tobacco and alcohol use, and improved family functioning and parenting outcomes.

5. Striving for Best Practice
We continue to strive for best practice and improve our service as informed by ongoing evaluation, engagement with the literature, consultations and engagement with our partners. In particular, we work closely with our referring agencies, CS, Mental Health (MH) and Alcohol and Drugs (D&A), and have developed a number of joint policies and procedures to enhance efficiency, open communication and collaboration. For example, to facilitate effective communication with CS, CS has identified a worker in their service to work as the WFT liaison. This person facilitates the referrals to us from CS and attends the WFT weekly allocation and clinical review meetings. Access to a consistent person to communicate with has allowed for transparency and a high level of familiarity of systems and processes across both health and CS. (See appendix 2 for an Information Booklet designed to facilitate collaboration with CS). As our primary partners in working with these families, CS, MH and D&A are regularly consulted to inform the ongoing development of the service and the ensure best practice. There are also strong partnerships with the other three KTS-WFT pilot sites and a great number of shared learnings.
D. INNOVATION IN PRACTICE AND PROCESS
The WFT model is innovative in that there is no similar service available in Australia that is under the governance and support of a mental health service. As noted, the KTS-WFT Gosford pilot is under the governance of CYPMH, CCLHD. By being integrated with CCLHD, the WFT is able to offer a level of mental health and drug and alcohol input that is not available through NGO settings. Furthermore, as noted previously, to our knowledge, there is no other service model that looks at the needs of all individuals in the family through collaborative partnerships and multidisciplinary interventions. The pilot project also contributes to the evidence pertaining to the effectiveness of intensive home-based treatment models such as provided by the KTS-WFT Gosford. While reviews of parent management programmes have demonstrated sound evidence to help mitigate child behaviour and mental health problems for a wide range of families (Piquero et al., 2008), evidence-based parenting programmes (Barth et al., 2005), and intensive home-based treatment models such as provided by the KTS-WFTs have not been widely tested (Ingram et al., 2013). This project and its extensive evaluation contribute to this knowledge.

E. APPLICABILITY TO OTHER SETTINGS
We have developed a detailed Model of Care that could be used by other KTS-WFT to guide service implementation (see appendix 1). While currently funding for KTS-WFTs is limited to four pilot sites, given the success of this intervention, there is a strong possibility that in time more KTS-WFTs will be implemented.

We have also written a detailed report outlining the findings of the KTS-WFT Gosford pilot evaluation; these findings will be widely disseminated through peer review publications.

F. REFERENCES
• Falkov A and Lindsay C. (2002) Patients as parents. Addressing the needs, including safety, of children whose parents are mentally ill Council Report. London: Royal College of Psychiatrists.
Table 1: Improvements in families’ strengths

Table 2: Reduction in families’ problems
Table 3:

<table>
<thead>
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<th>Domains and subscales</th>
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<td>Supervision of children</td>
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A. AIM
The CAAT Project aimed to achieve:
• Implementation of an evidence based and recovery oriented model of care;
• Improvement in quality, effectiveness and efficiency of acute mental health treatment;
• Increased acute treatment options for consumers, families and practitioners through providing short-term crisis resolution and acute home treatment;
• Decreased unnecessary inpatient admissions and
  Reduced prolonged hospital admissions through facilitated discharge.

B. ABSTRACT
Intensive home treatment for people with a mental health crisis is where the recovery-approach, trauma informed care and evidence-based practice converge. This project describes the redesign of the Blacktown acute community services towards a Community Assessment and Acute Treatment (CAAT) model of care including the redevelopment of 3 core functions for effective service delivery, including crisis resolution, acute home treatment (hospital at home) and early discharge facilitation from inpatient care.

The methodology of redevelopment included:
• Development of local evidence based best practice standards for crisis resolution and acute home treatment for people with mental illness;
• Benchmarking, pre and post team redesign using these Standards, to determine the levels of fidelity to best practice by the Blacktown CAAT Team;
• Leadership coaching of Team Leader though action Learning Sets;
• Team development through development of operational guidance for best practice;
• Skills training in the CAAT Team model of care of most team clinicians;
• Evaluation and monitoring of ongoing team functioning and impact.

The trends in the analysis of service data clearly shows positive outcomes from Quarter 2 of 2012 to the most recent Quarter in 2014, including:
• Reduction in inappropriate referrals through increasing clarity of the model;
• Increased access by people with “self-harm and suicidal behaviour”;
• Reducing repeat crisis presentations;
• Increasing the frequency rate and intensity of providing Acute Home Treatment for people with psychosis;
• Effective and psychotherapeutic crisis resolution for people with Personality Disorder;
• Managing acute demand for community treatment & maintaining stability in demand for inpatient hospitalisation;
• Expanding and enhancing linkage, partnership and interconnection with Non-government community mental health services;
• Increasing Access to Psychological and Psychiatric Therapies including with the private sector;
• Increasing levels of efficiency and effectiveness in crisis resolution through refocussing on people in acute need;
• Developing comprehensive packages of evidence based treatment and intervention.

C. APPLICATION OF ACHS PRINCIPLES
1. Consumer Focus
The local Western Sydney LHD Consumer Network and originally including consumers from the wider Sydney West and Nepean Blue Mountains Local Health Network, have been directly involved at all stages of development of the CAAT Team project. Specifically, consumers were directly involved in:
• Developing Standards;
• Trialling the Standards;
• Participation in a Focus Group;
• Advising on consumer need;
• Contribution to the planning of a CAAT conference including a workshop presentation;
• Developing the CAAT training curriculum;
• Training delivery;
• Team planning & redesign;

2. Effective Leadership
The approach has entailed a top down meets bottom up style of service transformation, activating the latent strategic as well as operational leadership capabilities at key levels of the organization. Specifically this has entailed the engagement of executive management, senior clinical leads, team leaders and importantly consumers in a multi-modal change process to redesign the structures and process to support a more efficient and effective model of care involved:
   i. Engagement
   ii. Assembling the evidence
   iii. Communication
   iv. Developing Standards
   v. Benchmarking
   vi. Organisational change strategy:
      a. Leadership Development
      b. Team Planning Days
      c. Team Operational Policy Development—guidance for day to day practice
      d. Skills training
      e. Embedded consultancy & supervision by senior clinician
      f. Developing clinical facilitation tools to support efficient practice
      g. Evaluation.

3. Continuous Improvement
• Service benchmarking: Initial baseline measurement and repeat monitoring of improvements in Fidelity to evidence based models of care using Standards.
• Training: Improving practitioner Core Capability by skills training.
• Consumers involvement in team development to enhance person centredness.

4. Striving for Best Practice
Blacktown Community Assessment and Acute Treatment Team, CAATT, is committed to provision of intensive, recovery oriented, evidenced based practice for people experiencing severe crises and episodes of acute mental illness and disorder in the least restrictive environment possible. Intensive community based for people in crisis or experiencing an acute episode of mental illness, is an area where the recovery approach, trauma informed care and evidence based practice converge. In repeated randomised controlled trials in Australia, the UK and the USA, consumers and carers consistently report high levels of satisfaction with the treatment received through this model of care. Meta-analyses of 8 randomised controlled trials showed reduced inpatient episodes, by up to 55%, improved clinical and social engagement with reduced burden on families and carers, with no difference in risk or frequency of serious incidents and at less cost1.

D. INNOVATION IN PRACTICE AND PROCESS
In 2013 as a prelude to the development of a mental health strategic plan, the Mental Health Commissioner of NSW, John Feneley announced that “NSW has ... more than double the number of beds than in Victoria though NSW’s population is less than one third larger .... NSW has maintained an excessive reliance on hospital as the place to get mental health care ... This must end”2. Apart from a few evidence-based examples of alternatives to acute inpatient care, for instance in the Victorian CAT teams and HASI in NSW, Australia is in urgent need of path finding clinical examples of how to redevelop, refocus and redesign acute home treatment services which have suffered a corrosive effect on effectiveness as fidelity to and funding for evidence based models of care has declined.

The function of acute home-based community care is an essential component of care for any contemporary mental health service. The foundation of this practice is grounded in the research, integrates with trauma informed and recovery oriented approaches, enjoys demonstrated high levels of consumer and carer satisfaction and is aligned with the universal human rights principle of treatment in the least restrictive environment3. This approach has undergone extensive international development and refinement2 over 30 or more years especially in the UK, Europe, the USA and New Zealand, including Victoria. Although this work provides an extensive literature on effective implementation and the sustainability of services in other settings, this arena of treatment and care is still widely acknowledged as one of the key gaps within community based services across Australia. In the Australian context, the capacity and capability to provide intensive home based treatment, to acutely mentally ill people who would otherwise be admitted to hospital, remains significantly wanting.
E. APPLICABILITY TO OTHER SETTINGS

The Blacktown CAAT Team experience demonstrates the feasibility of this safe, effective, efficient and much needed approach to evidence based alternatives to hospitalisation. While other examples of acute home treatment provision in Australia exist, the experience of the Blacktown CAAT Team uniquely offers an example of not only an effective and efficient complementary alternative to bed based services, but also importantly, clearly demonstrates a methodology for revitalising an evidence based approach to treatment and care for people when they are most vulnerable and at risk during crises. Both at state and national levels there is a great need for such beacon sites, which provide an insight into service redesign and redevelopment and an opportunity for scaling up and dissemination further a field of these efficient and effective services.

F. REFERENCES

- (1) Acknowledgement is given to the important early efforts of Suzanne Rix, Coordinator Consumer Network and the continuing efforts of Peter Turnbull A/Coordinator, WSLHD
- (3) John Feneley (2013). Living Well in the Community, pg. 10. Towards a Strategic Plan for Mental Health in NSW. MHC of NSW.
A. AIM
To increase the proportion of children who present to Emergency Departments within HNE Northern Clusters who access appropriate pain assessment and management within 12 months by:
• Standardising the assessment of pain in infants and children
• The introduction of Intranasal Fentanyl and other drug options
• Improving the confidence and competence of treating clinicians

B. ABSTRACT
Repeat audits of paediatric pain management in rural ED’s in Hunter New England Health showed children were under assessed and under managed for pain, despite ample literature and evidence to support the safety and efficacy of appropriate analgesia use in children of all ages. Baseline audit identified:
• 72% of children did not have pain assessment
• 60% of children did not receive appropriate analgesia
• 90% of clinicians surveyed did not feel confident assessing pain in children
• 87% of clinicians didn’t know about or did not use pain scoring tools
• There was no standardised system in place to facilitate an evidence based approach to assessing or managing pain in Emergency Departments

Implementation of a targeted intervention encompassed:
• 16 rural health facilities
• 700 chart audits
• 47 education sessions
• 387 clinician engagements
• 15,000 km travelled in 12 months
A consistent approach was applied at each of the Health Services with the following elements:
• Agreement on outcomes to be achieved

C. APPLICATION OF ACHS PRINCIPLES
1. Consumer Focus
Hunter New England Health is committed to the principle of providing care of children as close to home as possible and this project focused on providing the tools, equipment and expertise to facilitate the smaller rural hospitals to deliver safe, evidence based best practice in a standardised approach thereby providing equity of access for rural children to effective pain management.

2. Effective Leadership
Consultation: HSM’s, General Managers, VMO GP’s and clinicians were informed of the project and their support gained with agreement on goals and outcomes.
Governance: Clinical Governance Unit support gained through Innovation Support Scholarship
Communication: Ongoing education and mentoring for all clinicians (medical and nursing) in emergency departments with provision of pain...
assessment tools, charts, pain management manuals, prescribing guidelines and tools and equipment. Audit and feedback regularly with case discussion and stretch goals identified.

**Benchmarking:** Identification of best practice via literature and benchmarking with other health facilities identified newer more effective drug options.

**Leadership:** Presentation of project outcomes has occurred at local and state level with NSW Kids and Families and NSW Children’s Healthcare Network CNC group implementing the project in many other LHD’s within NSW rural and regional centres.

### 3. Continuous Improvement
- Ongoing audit and feedback took place to ensure sustained gains
- Paediatric pain management as a priority has been communicated to educators and managers for inclusion in all aspects of emergency care education.
- Recommendation has been made that where there is an identified departure from best practice around pain assessment and management that this is registered with the state wide IIMS database for follow up.
- Mechanism has been developed between rural GP’s and Regional Paediatricians for regular case discussion in the form of M & M meetings to identify issues generally with paediatric presentations and specifically as another avenue to address pain management strategies where applicable.

### 4. Evidence of Outcomes
Improvements were seen across all key indicators of the project over 12 months:
- Pain Score improved from 28% at baseline to 76% post intervention
- 69% of sites showed improvement in number of children receiving analgesia in ED.
- 75% of patients were given appropriate analgesia after the intervention compared to 10% prior
- The time to analgesia decreased from 38mins down to 11mins post intervention
- Pain reassessment increased from 9% to 49%

Clinician survey at baseline identified poor rates of confidence and knowledge around paediatric pain management which improved significantly post intervention across all key indicators. 80% felt both comfortable and confident with knowing which analgesic was appropriate for use in mild, moderate and severe pain in children compared with 28% at baseline.

### 5. Striving for Best Practice
**What does this really mean for a child who presents with a painful condition?**

**Pre Intervention management at a rural ED:**
- A 14 year old developmentally delayed child presented to a rural ED with her mother at 1600
  - Mother very concerned there was an injury following a fall from her bed, child distressed.
  - Arrived 1600, MO review 1615, D/C 1630
    - Incomplete observations/assessment
    - NO pain score (documented as “Difficult to assess pain”)
    - NO analgesia
- Discharged to return for xray next day
- Represented next day for Xray after being distressed at home overnight
  - Xray – complete fracture of humeral head (snapped off)
- Transferred to Tertiary centre for surgery that day (still no analgesia)

**Same Facility: post Intervention management**
- 7 yo MBA with compound fracture left humerus
  - Full observations, repeat observations, Pain score \( \rightarrow \) Severe
  - Paracetamol + Ibuprofen given immediately while awaiting MO, IN Fentanyl stat on review within minutes.
  - Pain score repeated \( \rightarrow \) mild
  - T/F for surgery with ongoing IV narcotics.

**THIS WAS A SIGNIFICANT CHANGE FOR THAT CHILD!**

### D. INNOVATION IN PRACTICE AND PROCESS
The elements that contributed to sustained improvements seen in this project are:
- Collaborative approach to a widespread issue that affects multiple facilities.
- Taking the regional specialists to the rural coal face
- Joint ownership of the problem – breaking down the silo’s we often work in
- Bringing innovation and new technique to every health service, not just the centres of excellence

### E. APPLICABILITY TO OTHER SETTINGS
A standalone module has been developed with audit tools, education resources and pain assessment scales, charts and guidelines. Integration with Between the Flags Standard Paediatric Observation Charts education has been embedded into practice. This is transferrable and replicable at other sites.
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Country Health South Australia Local Health Network
Safety and Quality Unit
BloodMove Project
Merrilee Clarke & Rick Tocchetti

A. AIM
To implement a novel red cell wastage minimisation program across regional South Australia (SA) which incorporates 62 regional hospitals with and without on-site laboratories and a multiple transfusion laboratory network. The program enabled hospital stored emergency standby and unused crossmatched red cells to be accepted back into transfusion laboratory inventory.

B. ABSTRACT
The health care needs of regional South Australia (SA) are covered by Country Health SA Local Health Network (CHSLAHN); the largest health network in Australia. The significant geographical and logistical challenges of SA presented a number of challenges to the supply and maintenance of emergency standby red cell stocks and it was noted that 100% of unused red cells were wasted; 60% was due to cold chain reliability and 40% due to expiry.

To assist with minimising wastage the program titled “BloodMove” was implemented across CHSLAHN with the support of SA Health Blood Organ and Tissue Program.

Cold chain assurance of regionally held red cells and the logistics in the rotation of those unused units back to the supplying regional and metropolitan transfusion service laboratories prior to expiry needed to be standardised to ensure wastage reduction.

To assist with this an ongoing replacement of ageing blood refrigerators, revalidation of blood shipment systems and changes in processes was implemented. This was done in collation with on-site education programs which included blood refrigerator oversight, blood shipper packing and the development of a blood and blood product inventory manual, procedures, forms, registers and audit tools to ensure standardised best practice across CHSLAHN.

Regional and remote hospitals were partnered with a primary supplying transfusion laboratory to oversee blood refrigerator temperature and testing records as well as blood storage confirmation documentation.

BloodMove is now part of normal accepted practice in country SA. A recent highlight was that zero red cells were wasted in the whole of regional SA in February 2014. BloodMove now investigates any wastage incidents to see if any shared learnings can be initiated to prevent waste occurring in the future. Wastage of blood in CHSLAHN which was once considered unavoidable is now deemed unacceptable.

The changes in processes have been well accepted by all multidisciplinary stakeholders, who are aware of their obligation to donor, patients and the wider community to ensure safe and appropriate transfusion practice, whilst minimising unnecessary wastage of blood products and the healthcare budget.

C. APPLICATION OF ACHS PRINCIPLES
1. Consumer Focus
Blood is a precious resource that is freely donated by volunteers to the Australian community. While blood is provided without charge to South Australian Hospitals and patients, it is not free to produce. All CHSLAHN staff has an obligation to donors, patients and the wider community to ensure safe and appropriate transfusion practice while minimising unnecessary wastage of both product and the healthcare dollar. This obligation is in line with the Australian Health Ministers’ Conference (AHMC) Blood Stewardship Statement.

2. Effective Leadership
BloodMove has a dedicated team which comprises of two state project leads; a Nurse Management
Facilitator and Medical Scientist and seven regional Clinical Nurses. These key implementation roles are supported by six Regional Director of Nursing and Midwifery (DONM) and site blood contact nurses.

The BloodMove team reports to a central Transfusion Committee which consists of an expert group representing Regional and Metropolitan Medical, Nursing, Executive, Safety and Quality, Transfusion Laboratory Managers and Australia Red Cross Blood Service. It meets bimonthly with particular focus on reducing blood wastage, emergency blood and blood product placement, development of procedures and implementing new Patient Blood Management Guidelines and provides leadership and support to the BloodMove team. These standing agenda items ensure that aspects of NSQHSS Standard 7 are met.

This is further supported by six regional Standard 7 Working Groups that also report to the CHSALHN Transfusion Committee and ensure that each region ensures best practice in relation to blood and blood products.

3. Continuous Improvement
BloodMove utilised the continuous practice improvement methodology and was initially implemented in one Regional area. Once evaluated and outcomes measured it was implemented utilising a staggered approach across Country Health sites. BloodMove has implemented a coordinated model incorporating regional hospitals with regional and metropolitan transfusion service providers in accordance with state and national guidelines and strategies while addressing local blood needs and geographical requirements. Local ongoing management, audit and communication were established using the network of regional clinical nurses and hospital contact nurses. Hospital documentation of cold chain was provided to receiving laboratories allowing previously discarded red cell units to be returned to inventory.

BloodMove has strived to be innovative, flexible, inclusive and approachable in the implementation of the project with communication and education ongoing between all stakeholders; such as CHSALHN Hospitals, Pathology Service Providers, Retrieval services, Couriers and Service Engineers.

This supportive network has been established to ensure that best practice is maintained across CHSALHN. Stakeholder feedback and suggestions are actively sought and acted upon by the BloodMove Team. BloodMove regularly presents at state and local stakeholder management meetings to ensure that information is disseminated and that issues raised are discussed and addressed in the correct forum. BloodMove Team members performs regular CHSALHN sites visits and conducts in-service educational sessions that cover all aspects of blood and blood product inventory and cold chain management. A regular education program with CHSALHN Regional and site nurses is maintained facilitating ongoing knowledge and awareness of BloodMove.

4. Evidence of Outcomes
Since its commencement, BloodMove has reduced avoidable red cell wastage in CHSALHN from a high of 15% in 2007/08 to less than 1.1% in 2013/14 which is 0.4% below FY 2012/13. Of note in 2013/14 was the achievement of 0% wastage for February 2014. This significant reduction has contributed to ensuring SA blood wastage is the lowest rate in Australia. Graph one illustrates the significant reduction in wastage that has been achieved across SA.

The data (Figure 1, over page) has been sourced from the SA Health Safety and Quality Report and measured against the SA Health wastage target rates which are based on the NBA requirements and costing’s for blood and blood products.

In monetary terms if BloodMove was not implemented and the 2007 wastage rate had continued then the cost of total blood wastage across CHSALHN would have been approx. $1.5 million. This equates to a cost saving per year from a high of $235,000 in 2007/08 to a low in 2013/14 of $27,000.

Within SA BloodMove has been expanded by SA Health Blood Organ Tissue (BOT) to incorporate the public and private transfusion laboratories so that available blood resources are shared where they are needed rather than expiring unused. SA now has the lowest wastage rate of red cells in Australia.
This achievement has been recognised by the National Blood Authority (NBA) and BloodMove has been showcased on the NBA website as a practical best practice model to assist other jurisdictions and health services with achieving blood wastage minimisation as specified in the National Safety and Quality Health Service (NSQHS) Standard 7 Blood and Blood Products and the NBA Blood and Blood Product Wastage Reduction Strategy 2013-17. A number of states and Japan have expressed interest in adopting the successful BloodMove model.

BloodMove’s uniqueness and success has also been acknowledged internationally, nationally and locally with invitations to present talks and posters at the following conferences:

- International Society of Blood Transfusion (ISBT), Seoul Korea, June 2014
- Haematology Australian Association/Australian New Zealand Society of Blood Transfusion Conference, Gold Coast, October 2013
- National Blood Authority Symposium, Adelaide, September 2013
- Australian Red Cross Blood Service, Transfusion Update, Brisbane, May 2013

BloodMove has also been recognised for its achievements and was awarded as the winner of the

- 2013 Australian College of Health Service
- Management (SA Branch) Award for Innovation and Excellence.

BloodMove has achieved a significant shift in attitudes across regional SA on important issues such as blood-related costs, inventory management and minimising avoidable blood wastage. If any incidents relating to wastage occur, they are reported through the SA Health Safety Learning System (SLS). These incidents are then investigated and managed appropriately at a local, regional and state level. Gaps are addressed and if required processes changed to ensure there is no reoccurrence of the incident.

Change has been brought about by the education provided by BloodMove site visits detailing the sense of blood stewardship and ownership in their duties whilst the blood is in their possession. CHSALHN hospital staff and transfusion laboratory staff now are mindful of any blood wastage and question and attempt to resolve all causes whereas in the past such wastage was accepted as unavoidable.

5. Striving for Best Practice

BloodMove stewardship has become part of customary accepted practice at all sites across country SA. All team members are empowered to investigate any wastage incident to identify opportunities for practice improvement. This
ensures the ongoing sustainability and efficiency of blood and blood products.

To ensure success, sustainability and maintenance of best practice BloodMove strives to be innovative, flexible, inclusive and approachable in its implementation; communication and education is ongoing between all stakeholders; CHSALHN Hospitals, Regional, Metropolitan, Public and Private Pathology Service Providers, Couriers and Service Engineers. Participation and feedback from all stakeholders has been welcomed.

By establishing a network of regional DONM Leads, Clinical Nurse, Standard 7 working groups and hospital contact nurse an effective coordination and continuity of care in CHSALHN regions and hospitals with regional and metropolitan transfusion service providers to assist with local blood requirements.

BloodMove has not only reduced blood wastage and ensured a significant cost saving but has also been able to assist CHSALHN, its regions and hospitals to comply with the 2012 National Safety and Quality Health Service Standard 7, Blood and Blood Products.

D. INNOVATION IN PRACTICE AND PROCESS
BloodMove is an innovative and collaborative program between Country Health and SA Health Blood Organ and Tissue Programs (BOT).

To ensure success, sustainability and maintenance of best practice BloodMove strives to be innovative, flexible, inclusive and approachable in its implementation; communication and education is ongoing between all stakeholders; CHSALHN Hospitals, Regional, Metropolitan, Public and Private Pathology Service Providers, Couriers and Service Engineers. Participation from all stakeholders has been welcomed.

Appropriate cold chain security processes, ongoing education, training and development of applicable forms, manual, procedures and audits tools have been established after consultation with all stakeholders. This has contributed to a significant cultural change in relation to blood stewardship and ownership by staff whilst the blood is in their possession.

Safety of transport, receipt, storage and product administration of the product has improved. Transfusion service providers and hospital staff are now mindful of correct processes to reduce blood wastage. Staff now question and attempt to resolve any causes of potential and actual waste, whereas in the past such wastage was accepted as unavoidable.

BloodMove has developed and imbedded a strong culture and person commitment amongst hospitals and laboratories resulting in an understanding that avoiding blood wastage is possible, worthwhile and normal practice.

BloodMove has encountered extra costs. This has included the upgrade/replacement of blood refrigerator assets in regional SA via an extensive blood fridge survey which identified gaps in fridge maintenance. This initiated a focused replacement program and has resulted in 18 new blood fridges being purchased, ensuring all blood and blood products are stored correctly according to current Australian Standards AS3864-2012.

To counter this increase in cost, BloodMove approached and partnered with the SA Health Immunisation Department regarding storing vaccines in blood fridges. This has resulted in a reduction in asset replacement by having one continuously monitored blood fridge on site. This has not only reduced nursing and maintenance staff time with daily checking and maintenance of the fridges but also ensured that vaccines have a higher level of cold chain security.

The BloodMove model can be applied to other jurisdictions to help reduce wastage. BloodMove has developed standardised tools that can be adopted by other organisations and local health networks, with a flow chart on how to implement BloodMove. The resources and infrastructure that have been developed can also be applied to other temperature sensitive therapeutics such as immunoglobulin’s, vaccines and medications.

The standout features and strengths of BloodMove program are: effective two way communication, appropriate cold chain security processes, ongoing education and training and creating a sense of stewardship, including ownership of blood-related processes.

E. APPLICABILITY TO OTHER SETTINGS
Following the success of BloodMove in CHSALHN, SA Health Blood Organ and Tissue Programs and SA Pathology has expanded the program to incorporate the private hospital sector within metropolitan Adelaide.

Additionally BloodMove has contributed to addressing “hub to hub” blood inventory
management between metropolitan public and private transfusion laboratories so that available blood resources are shared where they are needed rather than expiring unused.

The network model applied to the BloodMove Regional Clinical and Hospital Contact Nurses has also been adapted to other safety and quality standards within CHSALHN.

Template documents and process flow charts have been developed and made freely available to other states and territories and health services via the SA Health BloodSafe and NBA website. A number of states have adapted the BloodMove model utilising the tools available on the NBA website and more recently the Japanese Blood Service has been in communication and are considering implementation of “Japanese BloodMove”.

The resources and infrastructure that have been developed with red cells have also been applied to other blood products and can also be applied to other temperature sensitive therapeutics such as immunoglobulins, vaccines and medications.

F. REFERENCES

• (1) Australian Commission of Safety and Quality Health Care, National Safety and Quality Health Care Service Standards, Standard 7, September 2011.
• (2) Australian Council on Healthcare Standards, Australian Council on Healthcare Standards, EQuIP 5 Blood and Blood Products 1.5.5.
• (3) Australian Health Ministers Conference (AHMC) Statement on National Stewardship Expectations for the supply of Blood and Blood Products, 12th November 2010.
• (8) National Pathology Advisory Council, Requirements of Transfusion Laboratory Practice, 2012.

G. ACKNOWLEDGEMENTS

The BloodMove Project was founded by The Department for Health and Ageing’s Blood, Organ and Tissue Programs Unit within SA Health. The Unit, since BloodMove’s implementation, is a continuing sponsor and supporter of this project.
Figure 2: The journey of blood includes its transport to close and remote destinations, storage at those sites and then its return back to the supplying transfusion service laboratory. All these steps of the journey requires astringent cold chain security measures such as compliant blood shippers, blood refrigerators and completion of necessary documentation.

Figure 3: The Country Health SA Local Health Network Blood and Blood Products Inventory Manual was updated and provided to all hospital and laboratory stakeholders. The aim of the Manual is to provide guidance to all country South Australia (SA) regional, rural and remote health services on the appropriate storage, transportation, inventory management and minimisation of wastage of blood and blood products.

Figure 4: South Australia has some remote destination challenges in the provision and rotation of blood.

Figure 5: Cold chain security of the blood’s journey includes the use of blood refrigerators compliant with Australian Standards, the use of validated blood shippers and documentation to verify each step.
A. AIM
To improve performance in measures relating to quality of consumer experience and engagement through redesigned recruitment, retention and staff induction processes utilising local solutions and resources.

B. ABSTRACT
Consumer engagement and experience of mental health care in rural and remote NSW is negatively impacted upon by significant challenges in the recruitment and retention of high performing staff (Chisholm, M. et al. 2011). By undertaking process redesign using CORE values as a framework of recruitment and retention, Mehili/McIntyre Mental Health Service was able to demonstrate increases in performance across a range of domains using a values based approach to new staff. This process redesign demonstrates that by using a value based approach distance and rurality can be overcome as a barrier to a quality workforce, which in turn demonstrates improvement in indicators of consumer engagement and experience.

C. APPLICATION OF ACHS PRINCIPLES
1. Consumer Focus
Focusing on values-based recruitment and retention redesign, this project has resulted in improvement across a range of domains which are indicators of quality customer service. Indicative of this change is the absence of complaints received by the service over an eighteen-month period, and the absence of negative feedback received from regular reviews of the service by the Official Visitors Program. Through attracting and then fostering those staff who engage positively within a values based framework, not only have we demonstrated significantly improved performance in regards to consumer engagement but we have also increased the quality of our partnerships with our key stakeholders.

2. Effective Leadership
Through the delivery of this project, Mehili/McIntyre Mental Health Service has displayed leadership across other rural and remote services within the local health district in the delivery of quality clinical services through over-all adoption of values based approaches to operational management.

Whilst undertaking this project the service has demonstrated an innovative way of approaching operational management activities through a values-based framework with the goal of positively affecting consumer outcomes.

Evidence collated from meetings minutes, newsletters, quality reports and staff education data-bases shows that more than just delivering high quality consumer services, Mehili/McIntyre Mental Health Service Staff are increasingly empowered and supported to move beyond simply executing their job descriptions to becoming a strong voice for improving consumer outcomes both locally and throughout the service.

3. Continuous Improvement
Ensuring that the project could deliver continuous improvement beyond the initial roll-out was a deliberate part of its initial design. Essential to the process was the implementation of the following strategies to ensure that consistency was maintained and that consumers and the community continued to experience a quality service:

- Integration of some components of our redesign into district wide processes.
- Engagement of existing staff in contributing to the program.
• Documentation and creation of resources to support implementation.
• KPIs from this project collected through Monthly Accountability Meetings.
• Aspects of this redesign monitored through 30 and 90 day conversations, staff rounding and initial PDR.

4. Evidence of Outcomes
Standard performance measures of consumer engagement in addition to qualitative data such as staff rounding, 30 and 90 day conversations, exit interviews and individual performance reviews, undertaken at the completion of all staff’s first three months with the service was used to demonstrate the following outcomes within the service:
• A 56% increase in the number of consumers being seen within their allocated triage time.
• A 63% increase in the client contacts undertaken by the service.
• A 34% reduction in the number of clients not seen over 90 days.
• A 20% increase in the amount of direct clinical time spent with consumers out of the entire work hours.
• Vacancy rates have reduced from 55% to 0% over the life of the project so far.
• Staff turnover rates have reduced from 55% to 12%

5. Striving for Best Practice
As previously stated, consumer satisfaction increased substantially during the course of this project. Using qualitative and quantitative methods the team demonstrated that through innovation and values based approaches to the recruitment and management of staff in rural and remote services, consumers experience and outcomes could be affected with little to no change to existing clinical processes. This is in line with international best practice models such as the Studer Group model of Excellence (Studer, 2014) and research into telehealth models of practice and other rural and remote based research into use of technology to bridge geographical isolation.

D. INNOVATION IN PRACTICE AND PROCESS
In regards innovation in processes, whilst the idea of reflecting values in staff behavior is not new (Studer, 2014), the team has taken this further to examine a processes for critical analysis of the narratives created when the service recruits and selects its staff.
In regards to innovation in practice the team has demonstrated that through creative approaches the service can develop new practice models which utilise existing resources and human capital to deliver quality services to communities in rural and remote environments.

E. APPLICABILITY TO OTHER SETTINGS
This project has potential to be utilised across a wide range of public sector services due to its values based structure. Whilst this project occurred in the context of a community mental health service the process and underlying ideology is applicable to any organisation seeking to improve customer service through the recruitment and retention of quality employees who successfully reflect the organisations values.

F. REFERENCES
A. AIM
To decrease wait time issues, increase patient privacy and ensure ongoing integrity of patient records in the outpatient setting, through the introduction of a patient self check in system, the electronic queue management system (e-Queue) at Austin Health.

B. ABSTRACT
Large health organisations typically have long patient wait times in specialist outpatient clinics. With over 270 clinics, Austin Health is the first hospital in Victoria to introduce an electronic queue management system (e-Queue) to address wait time issues.

In addition to reducing wait times, the Austin’s innovative e-Queue system was designed to increase patient privacy and ensure the ongoing integrity of patient records.

The project initially targeted 10 crowded clinics with the longest wait times. Patients in clinics with the most need benefited from the resulting improvements.

Check-in kiosks were installed and robust baseline data about patient flow was collected. In consultation with clinicians, clinic schedules were then changed and patient flow was monitored.

Key outcomes are:
- Patients are in control of their own details, which are updated at every visit
- Information at check in is provided in 5 community languages other than English
- Clinics are quiet, orderly and no longer overcrowded
- Many clinic wait times are reduced, several demonstrating a 30-50% reduction.

The project is now strongly supported by all stakeholders, including clinicians, and the system will be progressively rolled out across Austin Health campuses. The long-term aim is for every clinic to have an average wait time of 20 minutes.

C. APPLICATION OF ACHS PRINCIPLES
1. Consumer Focus
The issue of long waiting times in out patients clinics was raised directly by consumers, and provided the impetus for the initiation of the project. In addition to reducing the wait times the Austin’s innovative e-queuing system was designed to increase patient privacy and ensure accuracy of patient records.

Consumers’ feedback has been sought for the project at key milestones, and the Austin’s Community Advisory Committee has also provided valuable input and advice. Consumers continue to be involved in the implementation and roll out of the system to each outpatient site.

2. Effective Leadership
Austin Health embarked on the implementation of the electronic queue management system with the objective of addressing long wait times, increasing patient privacy and ensuring ongoing integrity of patient records. The introduction of this system has provided a platform whereby wait time issues and patient flow can be addressed through the analysis and monitoring of data that was not available previously. This self-check in system is the first application of such a system in a large teaching hospital in Victoria and has provided benefits to the patient experience, to staff time management, provided potential for cost savings and ensured reliable data to drive efficiencies.

3. Continuous Improvement
Regular planned feedback gained from both patients and staff has provided valuable opportunities to further enhance the system. This has resulted in additional improvements such as improved signage for consumers, higher screens on the self check in machines to increase privacy of personal details, volunteer assistance...
commencing at an earlier time and staff re-training on using the e-queuing software.

4. Evidence of Outcomes
Overall, the patients report excellent outcomes with reduced wait times, with clinics that are quiet, orderly and no longer over crowded. In addition, clinical and other staff are satisfied that patients are more relaxed, with less aggressive incidents and that there is better flow through clinics, with clinics able to finish on time. Patient details are now updated at every visit and the information at check in is provided in five different community languages.

The system therefore includes innovations that address Austin Health’s challenges around the integrity of patient information and patient privacy.

5. Striving for Best Practice
Self check in has put the patient in control of the interface between their information and the hospital system. The kiosks have brought other welcome benefits including enhanced privacy and elimination of language barriers, whilst providing real time data and information that has been used to improve scheduling.

D. Innovation in Practice and Process
This e-Queue self check in system is the first application of such a system in a large teaching hospital in Victoria. The initiative demonstrated excellent change processes to gain clinician and patient support and to change entrenched scheduling practices. Patients were advised of all changes and remain involved in the ongoing review of the initiative and in advising about potential improvements.

E. Applicability to Other Settings
The e-queuing system has the potential to be adopted in any outpatient setting and provide many similar benefits to patients and staff.
A. AIM
Setting up of an Interactive Competence Training Centre to ensure competency, knowledge and skills of frontline supporting staff on Occupational Safety and Health (OSH) and related subjects such as handling of hazardous substances, wastes segregation and manual handling operation (MHO) through hands-on practice and innovative presentations of hospital risks.

B. ABSTRACT
About 25% of workforce in hospital is support workers who play a significant role in the smooth running of hospital services. Shortage and high turnover of support workers are critical issues in many hospitals in Hong Kong. By nature, hospital service is complex and is operating at a unique work environment that requires specific knowledge, which demands strict compliance. Lack of knowledge of newly recruited staff on safety guidelines and legislative requirements, and the inexperienced support workers impose potential risks to the environment, public, patients and staff.

An Interactive Competence Training Centre (ICTC) which represents a miniature of real-life situations was established in March 2013 with an aim to delivering practical training for support workers. This training program emphasizes on active participation and teamwork. Besides, a ‘play and see” approach was adopted to foster a lively learning environment. To ensure understanding of each subject, participants are required to complete the required tasks using the fake objects which replicate real-life hospital settings. There are fake amputated limbs from Halloween shop, make-up urine bags and stained gauze etc., being used for teaching in wastes segregation and types of clinical wastes. The setting up a mini toilet, kitchen and bed unit is used to illustrate color coding system for mops and wiping cloths. In addition, there are 5"S" section, spillage recovery demonstration, and MHO section, where participants are encouraged to practice the proper handling of store items, clinical wastes spillage and heavy goods. In essence, the ICTC is to provide practical training on OSH and infection control practices that are critical in hospital settings. It cover environmental hygiene, handling of spillage, house-keeping using 5"S" concept, waste segregation, identification of warning labels, alerts to infection control risks in different areas within the and good posture in MHO.

All newly recruited support workers of Supporting Services Department are mandatory required to attend the training in this center within the first week of service. Serving staffs are also invited for refresher training. Junior supervisors are the trainers of this Centre. They are engaged in the training to strengthen their daily monitoring of support workers in carrying out OSH and other safety related tasks. An Interactive Group Training Model has been devised, which emphasizes on hands-on practice, active participation and teamwork. Participants are organized in groups with serving staff and new recruits. Members of the same group are encouraged to speak-up and point out the mistakes in order to get high scores. The sessions are usually filled with fun and excitement, yet learning is well-sustained.

As of July 2014, 66 sessions of training have been arranged since its opening in March 2013. Over 350 workers in Supporting Services Department which included cleaners, porters, drivers and patient care assistants attended the training. Active participation was observed with 100% passing rate and the highest score was 91.5. Training for ward staffs as trainers, including nurses, ward managers and supervisors has also been organized and with very good feedbacks.

The Evaluation Survey on this Centre showed that participants were highly receptive to the training
given. In a 5-point scale (1 for “Strongly Disagree” and 5 for “Strongly Agree), results were as follows: (i) Willingness to attend similar training in future (3.97), (ii) “play and see” approach can enhance understanding of the subject matters (4.07), (iii) opportunity for participation (4.02), (iv) quiz and group competition were fun (4.12) and (v) good learning atmosphere (4.16). The mean score of Staff Knowledge and Skills acquired through this ICTC was 16.63% higher than that of conventional training in classroom. The mean score of Knowledge Retention after 6 months was further increased by 7.89%. In conclusion, the ICTC and the Interactive Group Training Model is more effective than the conventional training. Staff knowledge could be enhanced through hands-on practice, group learning and participation. More importantly, staff safety and retention can be achieved.

C. APPLICATION OF ACHS PRINCIPLES

1. Consumer Focus

The establishment of the Interactive Competence Training Centre can accelerate the learning curve of frontline supporting staff. Through enhancing the knowledge and skills on various OSH and related subjects such as handling of hazardous substances, the support workers are more confident and competent in performing their daily duties in the hazardous environment of the hospital. The Interactive Group Training Model which emphasizes on hands-on practice, active participation and teamwork can provide effective means to sustain learning to this group of menial workers.

From the patient perspective, the higher level of staff competence ensures a safe and clean environment to patients, relatives, visitors and the public.

2. Effective Leadership

• The Hospital Chief Executive drives the project at a strategic level.
• The General Manager of Administrative Services is committed to promoting Occupational Safety and Health (OSH) and continuous staff development and training. She initiates, approves and supports the establishment of Interactive Competence Training Centre.
• The Senior Hospital Managers encourages frontline supervisors to participate in the design of the Interactive Competence Training Centre and engages them for the training.

3. Continuous Improvement

• The training content and program is reviewed on a regular basis or when new protocol, guideline or legislation is announced. Quality and Safety Department and Infection Control Team have been providing updated information for our training use.
• Post training evaluation on staff satisfaction and knowledge retention are collected and are used to devise enhancement of the program. Participants’ feedbacks are analyzed and incorporated in the subsequent training.
• Apart from training housekeeping workers and cleaners, this Interactive Competence Training program will also be rolled out to other grades of supporting staffs, like facility personnel and security guards.

4. Evidence of Outcomes

• 100% passing rate.
• Highest score: 91.5.
• The Evaluation Survey on this Centre showed that participants were highly receptive to the training given. In a 5-point scale (1 for “Strongly Disagree” and 5 for “Strongly Agree), results were as follows: (i) Willingness to attend similar training in future (3.97), (ii) “play and see” approach can enhance understanding of the subject matters (4.07), (iii) opportunity for participation (4.02), (iv) quiz and group competition were fun (4.12) and (v) good learning atmosphere (4.16).
• The mean score of Staff Knowledge and Skills learned through this Interactive Competence Training was 16.63% higher than the mean score of Conventional Training (Classroom Training).
• The mean score of Knowledge Retention (Post-6 months after Interactive Competence Training) was further increased by 7.89%.
• Interactive Competence Training was found more effective than Conventional Training.
• Staff knowledge was deepened through hands-on practice, group learning and participation.

5. Striving for Best Practice

• In collaboration with Quality and Safety Department, WISER Unit and Central Nursing Division, the establishment of this Interactive Competency Centre is highly responsive to the emerging training needs for frontline supporting staff.
• Visits from other organizations such as Vitasoy International Holdings Ltd., Mass
Transit Railway (MTR), Jockey Club, China Gas and Chinese University of Hong Kong were received and they were impressed by the contemporary and effective means of training. They found the innovative presentations of hospital risks by means of fake items were most fascinating.

- Train-the-trainer Workshops have been arranged to Central Nursing Division and other hospitals of Kowloon Central Clusters so as to enhance the knowledge of supporting staff of other departments and other hospitals.

D. INNOVATION IN PRACTICE AND PROCESS

- In the past, no structural training on Occupational Safety and Health (OSH) and related subjects such as handling of hazardous substances, wastes segregation and manual handling operation was designed for frontline supporting staff, only the so called “on-the-job training” was provided to frontline supporting staff.

- However, with the complexity of work environment in hospital and high staff turnover rate, a nouveau structural training to frontline supporting staff becomes an imminent need to ensure the competence of the support workers for providing a safe environment to the public, patients, visitors and staff. “Play and see” approach by means of innovative presentations of hospital risks could arouse interest of participants to learn the subject matters. The miniature hospital settings allow participants to grasp complex and diverse safety concepts at one spot. This “mini-hospital-around” can highlight the high risk areas and matters of critical concerns to new recruits under a lively learning atmosphere.

- Conventional training in classroom was ineffective in the delivery of job-related training to frontline supporting staff, the Interactive Group Training Model has ushered a new way of training which encourages learning through hands-on practice, “play and see”, active participation and teamwork.

E. APPLICABILITY TO OTHER SETTINGS

Using Interactive Group Training Model to enhance staff competence and promote teamwork is applicable to other settings with similar training targets i.e. training menial workers within a short period of time for complex subject matters. Types of hazardous substances found in hospital and safety guidelines and practices are ever changing.

Therefore, providing a sustainable platform to train high volume of staff with necessary knowledge to cope with diversified and complex work environment is not only beneficial to staff and management but also to the organization.
## Category: Non-Clinical Service Delivery

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Melbourne Health
Influenza Vaccination Working Party
Taking staff influenza vaccination rates to a record level
Peter Bradford, Nicky Webster,
Ms Kathryn Williams & Ms Irene Salkunas

A. AIM
To increase staff influenza vaccination rates from 45 per cent in 2012 to a target of 80 per cent vaccinated and 95 per cent compliant with documentation, with or without vaccination – the first such outcome for an Australian health service.

B. ABSTRACT
On average 2500 deaths occur in Australia each year as a result of influenza. Influenza can cause severe illnesses particularly in those with underlying medical conditions, resulting in hospitalisation and/or death. Up to 50 per cent of influenza infections can be asymptomatic, but both symptomatic and asymptomatic individuals can shed the virus and infect others. Getting vaccinated every year is important as the viruses continually change and immunity decreases over time.

The Melbourne Health staff vaccination rate was 45 per cent for 2010, 2011 and 2012. In 2013, the new Chief Executive announced a target compliance rate of 95 per cent (vaccination plus signed declaration form). This was one of the flagship initiatives under the newly launched Safety First program - to emphasise the critical importance of safety for staff, patients, clients and visitors.

Key issues that were identified at the commencement of the 2013 campaign included:
- Reinforcing the reasons for staff immunisation i.e. the safety of patients, clients, visitors and staff.
- Requirement for leadership at the Board, Chief Executive and Executive level to instigate a change in staff behaviour.
- ‘Real time’ data and support needed for managers to help them encourage their teams to be vaccinated.
- Processes were required to allow collection of ‘real time’ data.
- Staff required ready access to immunisers at central and remote sites and out of regular working hours.
- Influenza vaccination had to remain visible throughout the course of the flu campaign. We needed to address common misconceptions held by staff about the influenza vaccine.
- An ability to evaluate the 2013 campaign and utilise learnings for 2014.

The Influenza Vaccination Working Party was asked to “think outside the box” and develop an innovative approach to address these issues and ensure staff engagement.

Four key changes were implemented by the working group in 2013 and carried through to the 2014 program:
- A weekly report of the number of staff vaccinated by ward/department was generated.
- All staff and volunteers were required to complete a form, Influenza Vaccination Declaration 2013/4, indicating if they were vaccinated at Melbourne Health, vaccinated elsewhere or were choosing to opt out of being vaccinated and their reason for opting out.
- Greater accessibility to vaccination was provided by creating a ‘Flu Stop Shop’ in the ground floor retail precinct at The Royal Melbourne Hospital City Campus as well as a team of roving nurse immunisers across Melbourne Health’s 31 sites.
- An intensive staff engagement and promotional campaign, included posters featuring staff and their reasons for getting vaccinated, regular features in the fortnightly staff newsletter, an influenza progress monitor on the staff intranet and rewards for wards and departments who achieved the 95 per cent target.
Led by the Chief Executive, the working party undertook a literature search and embarked on an evidence-based multi-pronged strategy including:

1. An extensive staff education program about the importance of vaccination, beginning with a clear message from the Chief Executive delivered in multiple staff forums about the importance of influenza vaccination for healthcare workers and the reasons for vaccination.

2. The development of a real-time database by Melbourne Health’s Reporting, Information & Analysis Unit (RIAU) meant that the total vaccination and compliance rate could be regularly communicated to staff.

3. Reasons for declination were evaluated and used to inform the campaign. Many of the stated reasons related to unsubstantiated myths about influenza and influenza vaccination. Further education and communication was then undertaken to address those myths and misconceptions.

4. Leadership displayed by the Melbourne Health Board, Chief Executive, Executive Directors and senior clinicians by having photographs taken, getting involved in case studies and utilising email. Senior staff also actively promoted awareness of the flu campaign by wearing highly visible ‘flu’ lapel badges.

5. High and low performing teams were highlighted in the Chief Executive forums (Chief Executive presentations provided to staff at various Melbourne Health locations) to celebrate successes and to ensure that departments who were underperforming received a clear message about the expectation of the leadership team.

6. Vaccination compliance was a standing item during the weekly Leadership WalkRounds (Executive visits to various teams) during the campaign.

7. The recruitment of a mobile team of professional immunisers. The immunisers were available at The Royal Melbourne Hospital City Campus and they visited all 31 Melbourne Health sites and all wards at various times during the campaign, at all times of the day and night, including weekends.

8. The availability of ‘real-time’ data to give managers up-to-date information about the proportion of vaccinated staff in their Unit and the names of those not vaccinated so they were able to have a confidential discussion with that person. Extensive support was provided by Human Resources to help managers have these conversations with their staff in an appropriate manner.

9. A co-ordinated internal marketing and staff engagement campaign, comprising the staff intranet site with vaccination data updated daily, visible ‘flu’ lapel badges for vaccinated workers to maintain the high visibility of the campaign, posters reinforcing core messages and staff case studies, creative and eye-catching lift skins, regular email updates, PC screensaver reminders, staff competitions, an email address for staff to provide feedback on the program and social media.

10. The establishment and marketing of ‘real time’ vaccination progress was posted on the home page of the Melbourne Health staff intranet site. It included a graphical dial showing the percentage of staff compliant, the number of days remaining in the influenza campaign and the number of vaccinations required to reach the target.

11. The establishment of a highly visible ‘Flu Stop Shop’, an on-site hub offering free, fast, on-the-spot vaccinations at The Royal Melbourne Hospital City Campus (across from the most popular coffee shop). This was supported by the onsite privatised staff clinic to maximise staff access to the vaccine, before, during and after the influenza campaign.

12. Establishment of linkages with the new employee vaccination strategy so that new employees could be vaccinated as part of their immunisation assessment.

13. An innovative business case was developed by the Infection Prevention Surveillance Service, outlining the resources required to provide an immunisation service across 31 sites for 8000 employees. Executives were asked, and readily agreed, that they contribute to the campaign on a cost per head basis from their portfolio budget.

C. OUTCOMES

Where the Melbourne Health vaccination rate had languished at around 45 per cent over the
previous three years, the 2013 vaccination rate was lifted to 78.6 per cent (overall compliance 90 per cent) and in 2014 the vaccination rate is 80.2 per cent (overall compliance with vaccination or declination - 94 per cent).

Such was the success of the vaccination program that Melbourne Health was commended by the Victorian Minister for Health for this outcome and for our strategic approach to enhancing seasonal vaccination of staff. Subsequently, the Minister wrote to all Victorian hospital Chief Executives in June 2013 highlighting Melbourne Health’s success in 2013, and advised that the state-wide target for healthcare worker vaccination rates was to be lifted from 60 per cent in 2012 to 65 per cent in 2013. The state-wide target has since been lifted again to 75 per cent in 2014.

We have been advised that other hospitals have been inspired by Melbourne Health’s outcome and in 2014, they launched similar innovative campaigns.

F. APPLICATION OF ACHS PRINCIPLES

1. Consumer Focus

Following the appointment of Melbourne Health’s Chief Executive, Dr Gareth Goodier, in June 2012, a new approach to patient centred care was developed, entitled ‘Safety First’. Safety First is an initiative that builds on a solid base of safety improvement but also aims to take Melbourne Health further in the pursuit of excellence and to be a leader in safe practices for patients and staff.

The influenza campaign is an integral component of Safety First and resulted in optimising the protection of our patients, residents, clients, our 8000 staff, and their families and friends. In turn, Melbourne Health and its staff contributed to protecting the Victorian community from seasonal influenza and its attendant morbidity and mortality.

Melbourne Health follows the advice of the Victorian Department of Health, which is that hospital staff are asked to protect themselves and their patients and to be immunised every year well before the influenza season starts.

“Influenza affects your capacity to work and to care for patients, as well as your families. Staff who are clinically or sub-clinically infected can transmit the influenza virus to others especially patients at high risk. Patients at high risk can have a low antibody response to influenza vaccines. You can protect these members of high risk groups against influenza by reducing the likelihood of influenza exposure from yourself.”

2. Effective Leadership

One of the first organisation-wide initiatives launched under the Safety First banner was the staff influenza vaccination program, where an aspirational Melbourne Health target of 95 per cent vaccination compliance was announced by the Chief Executive in 2013, a first for any health service (public and private) in Australia.

An excerpt from the initial email from the Chief Executive to the organisation is below:

“This year’s influenza vaccination program is different in that:

• We have set a 2013 target for influenza vaccination take-up for staff and volunteers at 95%.
• All staff will be required to complete a vaccination declaration form indicating their consent for vaccination or their intent to opt out of the program.

Leadership was displayed across the organisation by:

• Participation by the Melbourne Health Board, Chief Executive, Executive Directors and senior clinicians in promoting vaccination by having their photographs taken and participating in case studies that were promoted across the organisation.
• Regular email updates from the Chief Executive at key milestones throughout the course of the campaign, supported by emails from senior managers targeting specific areas.
• Active involvement in Leadership WalkRounds and promoting the flu campaign during these visits to work areas.
• The campaign was launched with members of the Executive, senior clinicians and senior managers visiting all areas across Melbourne Health. Senior staff were given clear messages about the campaign for staff as well as balloons and lollies to raise awareness and engage staff.

Get vaccinated – it’s your best defence.”
• Attendance by the Chief Executive and Executive members at an ‘end-of-campaign’ afternoon tea to recognise high performing areas and celebrate the final result.

The Influenza Vaccination Working Party was led by the Executive Director Clinical Governance and Medical Services, and the Working Party embarked on an evidence-based multi-pronged strategy.

The multidisciplinary working party drew on the energy and expertise of representatives from Infection Prevention, Staff Health, Occupational Health and Safety, Nursing Workforce, Human Resources, Epidemiology, Victorian Infectious Diseases Service, Public Affairs, The Royal Melbourne Hospital (RMH), and NorthWestern Mental Health. The team met monthly between November and July each year and was responsible for developing and overseeing the program and maximising staff vaccination rate.

3. Continuous Improvement
Prior to 2013, the Melbourne Health staff vaccination rate for flu was stagnant at around 45 per cent for 2010, 2011 and 2012. With an ambitious target to work towards, a multidisciplinary Influenza Vaccination Working Party was established to radically review how we approached the annual influenza vaccination campaign with the objective of positively engaging all staff and volunteers so that they understood the importance of being vaccinated.

The ongoing work of this team saw a dramatic and sustained improvement in Melbourne Health’s influenza vaccination rates through the 2013 and 2014 influenza seasons. The 2013 vaccination rate increased to 78.6 per cent (overall compliance with vaccination or declination 90 per cent) and in 2014 the vaccination rate was 80.2 per cent (overall compliance with vaccination and declination 94 per cent).

5. Striving for Best Practice
The Working Party achieved a significant increase of the vaccination rate of greater than 78 per cent over two consecutive years and achieved more than 90 per cent total compliance. This was achieved in a very large organisation of more than 8000 people, with staff dispersed across 31 sites. This result is equivalent or better than other international healthcare institutions that employ a voluntary influenza immunisation program and close to those recorded where the program was made mandatory.

In comparison, the vaccination rates at other major Victorian hospitals were between 40 per cent and 68 per cent in 2013 with an average rate of 59.2 per cent vaccinated (latest available figure). This is compared to Melbourne Health’s 2013 vaccination rate of over 78 per cent. (source: Vic NISS).

Such was the success of the influenza vaccination program that Melbourne Health was commended by the Minister for Health in June 2013, in a letter to all Victorian hospital Chief Executives, for this outcome and for our strategic approach to enhancing seasonal vaccination of staff. As a result of Melbourne Health’s success in 2013, the statewide target for healthcare worker vaccination rates was lifted from 60 per cent in 2012 to 75 per cent in 2014.

G. INNOVATION IN PRACTICE AND PROCESS
Keeping the focus on the new Safety First initiative – for the safety of patients, staff and visitors alike – the importance of vaccination has been continuously emphasised. As a result, the aspirational target of a 95 per cent vaccination rate is viewed as critically important for the safety of all who come to the health service and all of its sites.

Safety First aims to take Melbourne Health further in the pursuit of excellence and be a leader in safety for patients and staff.

H. APPLICABILITY TO OTHER SETTINGS
The results of the 2013 and 2014 influenza vaccination program have, in part, been responsible for raising the Victorian Department of influenza vaccination programs. The 2013 vaccination rate increased to 78.6 per cent (overall compliance with vaccination and declination 90 per cent) and in 2014 the vaccination rate was 80.2 per cent (overall compliance with vaccination and declination 94 per cent).
Health's target for healthcare worker vaccination rates from 60 per cent in 2012 to 75 per cent in 2014.

Melbourne Health has proven that by providing a multi-pronged strategy, including communicating real-time information to all staff through many regular communication channels, that a large organisation can make a significant behavioural change amongst a large, diverse, staff base, at multiple work sites, including significant numbers of casual and shift workers. Melbourne Health is similar to many other healthcare networks in Australia, so the strategies used here would clearly be applicable to those institutions.

The outstanding success of Melbourne Health’s influenza vaccination program shows that an important safety initiative can be implemented in a very well-supported and managed environment.

I. REFERENCES

• Michael J Stuart, Review of strategies to enhance the uptake of seasonal influenza vaccination by Australian Healthcare workers, CDI Vol 36 No 3 2012.
• Talbot TR et al, Factors associated with increased healthcare worker influenza vaccination rates: results from a national survey of university hospitals and medical centers, Infection Control Hospital Epidemiology. 2010 May;31(5):456-62.

J. REFEREES

• Noleen Bennett, VicNISS Co-ordinating Centre
• Doctor Alan Hampson, Chairman of ISG and Deputy Director of the WHO Collaborating Centre for Reference and Research on Influenza
Some of Melbourne Health’s Flu Vax campaign channels

- Lift door promotions
- Desktop promotion
- Social Media

Comparison of Melbourne Health HCW Influenza uptake compared to Victorian State Average

- Melbourne Health: 79.63%, 78.60%, 41.80%, 47.80%, 44.30%
- Victorian Aggregate Uptake: 59.20%, 51.46%, 48.26%, 46.80%
## Influenza Vaccination

The most effective way to prevent influenza is through vaccination.

- **Vaccination** is a major defence against influenza. It lowers your risk of influenza and its complications.
- **Vaccination** is especially important for people at higher risk of serious complications from influenza, such as the elderly, children, pregnant women, and people with certain medical conditions.
- **Vaccination** is recommended for all ages, particularly for people in high-risk groups.

### Benefits of Influenza Vaccination

- Helps protect you, your family, and your community from flu.
- Reduces the risk of serious complications from influenza.
- Protects you and others who are more vulnerable to influenza.

### Guidelines for Influenza Vaccination

- Influenza vaccines are available for people of all ages, including children as young as 6 months.
- The exact type of vaccine recommended for a particular group depends on factors such as age, health status, and medical history.
- The vaccine should be given by a healthcare provider, either in a doctor's office, clinic, or hospital.

### Steps for Influenza Vaccination

1. **Identify Eligible Recipients**
   - Determine the age groups and medical conditions that are eligible for influenza vaccination.

2. **Order Vaccines**
   - Contact your healthcare provider or local pharmacy to order the appropriate vaccines.

3. **Administer Vaccines**
   - Administer the vaccines on the recommended schedule.

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<tr>
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<td>Adults</td>
<td>Combination Vaccine</td>
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### Influenza Vaccine Precautions

- Avoid giving live influenza vaccine to people who are at high risk of complications from influenza.
- Avoid giving live influenza vaccine to people who are pregnant.
- Avoid giving live influenza vaccine to people who have had a severe, life-threatening reaction to a previous dose of the vaccine.

### Common Cold vs. Influenza

- **Common Cold** typically causes a milder illness with symptoms such as runny nose, sneezing, and cough.
- **Influenza** is a more severe illness that can cause fever, chills, fatigue, and muscle aches.

### Take Home Point

- Influenza is a major threat to public health, and vaccination is the best way to prevent it.
- Vaccination is important for everyone, but especially for people at higher risk of complications from influenza.
- Influenza vaccines are safe and effective, and they help protect not only the vaccinated person but also those around them.
A. AIM
The aim of this initiative was to use patient experience to inform innovating change in the way we care for our patients whom undergo elective hip and knee surgery.

B. ABSTRACT
Methodology
A range of key stakeholders were identified and extensive patient input was garnered using a range of methodologies and as a result it was decided that the initial focus would be on increasing efficiency in the care of high functioning patients requiring uncomplicated hip and knee replacements. The primary measurement used for this initiative was average length of stay, and secondary measurements included:
1. Patient time spend in surgical review clinic;
2. Day of referral to rehabilitation
3. Implementation of standard post-operative patient journey pathways;
4. Duration of community rehabilitation initial assessment; and,
5. Access to post-discharge community services.

A work plan was agreed upon and tasks were undertaken using various methodologies such as patient lead interviews and lean redesign strategies.

Outcomes
Average length of stay across all cohorts has decreased by 1.44 and 2.59 days for total knee and total hip replacements respectively, and improvements were seen in all five of the secondary measurements. Furthermore, and perhaps most importantly, the resulting patient feedback was outstanding.

C. APPLICATIONS OF ACHS PRINCIPALS
1. Consumer Focus
This initiative was undertaken with a patient-centred approach to improving the way we care for our patients. Significant feedback was obtained from patients to better understand what improved care would look like for these patients, and the overwhelming response was a more efficient system of care.

2. Effective Leadership
The project and clinical care team have successfully led whole of system change in what was fragmented and multi-site service system. This occurred without additional project resources and within a fiscally constrained environment.

3. Continuous Improvement
The project team continues to meet regularly to progress the program of work and sustain the project gains by evaluating, refining and improving the model. Outcome data is reviewed and reported regularly to clinical and operations leaders to ensure accountability for the sustainability of this outstanding practice. Patient feedback will also be sought at regular intervals in the future.

4. Evidence of Outcomes
Reduction in average length of stay
Average length of stay for this patient cohort has decreased dramatically in the two years from FY2011/12 to FY2013/14 (as at May 2014). The average length of stay for total knee replacements and total hip replacements has reduced from 6.24 to 4.80 days and 7.06 and 4.47 days, respectively. This equates to a saving of over 646 bed days.

Surgical Review Clinic Efficiency Improvement
Allied health staff members now perform a comprehensive pre-operative assessment and commence the discharge planning process, resulting in:
- A 45% reduction in average time spent by patients in the clinic from 2.9 hours to 1.6 hours\(^1\);
• Care planning document commended whilst patient is in acute inpatient services as opposed to during sub-acute care;
• Elimination of patient re-assessment for transition from acute to sub-acute care;
• Ad hoc clinical feedback suggesting maximised patient ware therapy time; and,
• Ad hoc clinical feedback suggesting strengthened communication across the continuum of care.

Interdisciplinary Practice Improvements
The physiotherapy team is training ward nursing staff to assist patients to transfer out of bed and to encourage patient participation in exercises. Patients participate in group therapy rather than one-on-one therapy; enabling patient interaction and resulting in more effective use of health care resources.

Community Rehabilitation
This project recently appointed a project officer to review community rehabilitation processes for elective orthopaedic patients. As a result, these patients now commonly attend community rehabilitation therapy rather than Post-Acute Care and individual Rehabilitation in the Home sessions. Rehabilitation in the Home sessions used to be a standards referral; however they are not required by all patients, are labour intensive, and don’t allow group patient interaction.

Patient Survey Results
Patient survey results showed that of respondents (n = 39);
• 100% strongly agree or agree that they feel informed and empowered about their care, i.e. they understood;
  o What tasks they need to undertake prior to surgery;
  o What would happen during their hospital stay;
  o What occurs post-hospital stay (Post discharge).
• 100% strongly agree or agree that the information they received prior to surgery helped them to prepare for their admission to hospital;
• 100% found the written information they received was good or very good.

Clinician Survey Results
94% of clinicians surveyed (n = 15) reported that they now have a greater understanding of the total patient experience, and thus can provide more accurate advice.

5. Striving for Best Practice
Initially focusing on average length of stay reduction for high functioning patients requiring uncomplicated hip and knee replacements, the pathways were expanded to all elective hip and knee joint replacement patients in October 2013. Monash Health is striving to achieve and standardise best practice care across all sites.

D. INNOVATION IN PRACTICE AND PROCESS
This initiative is a true innovation at Monash Health, providing a new and sustainable patient-centred pathway for elective orthopaedic patients. Is was largely informed by the patients who have experienced, at times, a fragmented, unreliable system – and therefore the people best-placed to design a new model of care.

This pathway was presented to a national Operating Theatre Conference in 2014 and as a poster presentation for the Victorian Operating Theatre Conference in May 2014.

E. APPLICABILITY TO OTHER SETTINGS
This innovation in patient care is successfully embedded at Dandenong Hospital, and is being rolled out across orthopaedic inpatient services throughout Monash Health, including the Moorabbin Surgical Review Clinic and Kingstown Centre sun-acute wards.

Although this project specifically pertains to patients whom have undergone elective orthopaedic surgery, the principals of patient-centred design of care can be used to frame the landscape of change in the majority of healthcare settings.

F. REFERENCES
• (1) SRC Survey conducted by Brydie Quinn and Libby McGuire, Nov 2013 – March 2014.
## An eHealth approach to measuring mental health outcomes in a psychiatric mother–baby unit
St John of God Health Care
Perinatal & Women’s Mental Health, St John of God Hospital, Burwood

*Marie-Paule Austin, Carolyn Yin, Nicole Reilly & Bettina Christl*

## Preventing staff Slip, Trip and Fall (STF) injury in Operation Theatre
Hong Kong Baptist Hospital
Operation Theatre

*CHAU On Nei, YIU Yee Man, LAU Bo Ping, Wendy FONG, CHAN Yuk Sim & Samantha CHONG*

## Improving Clinical Outcome through the development of a well-structured Clinical Indicator Program
Union Hospital
Clinical Indicator Task Force

*Clara WU, HO Kin Kei, Florence FUNG, Mooris LAI, Kelvin MO & Jackson CHAN*

## Reviewing Indications and Prioritising Birth Induction
Hunter New England Local Health District
John Hunter Hospital Maternity and Gynecology Services

*Marianne Knox, Henry Murray, Mandy Hunter & Lyn Kramer*

## Dynamic Data – Developing a Compliance and Risk Data Report
Yarrawonga Health
Compliance and Risk

*Paula Nagle, Fiona Stevens & Elaine Mallows*

## Patient experience and expectations – establishing a structure aimed to improve service delivery through consumer feedback
Princess Alexandra Hospital
Executive Director of Nursing Services, Centre of Nursing Excellence

*Sandra Moss & Sue Boyd*

## Patient-centred innovation in orthopaedic patient pathways
Monash Health
Monash Health Patient Flow and Dandenong Hospital Orthopaedics and Operations teams

*Brydie Quinn, Ton Tran & Jane Poxon*

## Processes to Engage and Motivate Staff
Princess Alexandra Hospital, Brisbane Queensland
Nurse Practice Development Unit

*Sue Schoonbeek, Amanda Henderson & Anthony Auditore*

## Improving Patient Safety by Changing Clinician Performance Through Real Time Reporting
Gold Coast Hospital and Health Service
Resuscitation Coordinator under Specialty and Procedural Services and Nurse Manager, eRoster under People, Systems and Performance

*Deborah Stiles & Richard Oakham*

## The implementation of best practice frameworks to ensure a sustainable patient centred care model
St. Vincent’s Private Hospital Sydney
Nursing

*Kim Walker & Xanthe Jones*

## Taking staff influenza vaccination rates to a record level
Melbourne Health
Influenza Vaccination Working Party

*Peter Bradford, Nicky Webster, Kathryn Williams & Irene Salkunas*
Student Awards

Introduction

The Joint Medical Program (University of Newcastle and University of New England) requires the Year 5 Bachelor of Medicine students to study patient safety and quality in health care.

Students are required to carry out a quality project during their Critical Care course in which they do rotations in orthopaedic surgery, emergency medicine, oncology and anaesthesia/ICU.

The aim is to identify patient safety issues and apply the quality tools to determine areas for improvements and make recommendations.

The selection panel for 2014 nominated a winner and four highly commended mentions. Forty-five projects were submitted and were of a very high standard.

Each project is judged by the following criteria:

- An important problem was identified,
- Appropriate tools were used to analyse the problem,
- A recommended intervention was established,
- The outcome of the intervention was measured.

The Australian Council on Healthcare Standards enthusiastically supports this safety initiative by providing certificates of achievement and a small prize to each member of the successful team.
Audit of adherence of John Hunter Hospital Emergency Department Shift-Change Handovers to New HNE Local Health District Guidelines

Steven Alley, Kenneth Boldery, Ashley Everson, Sebastian Furneaux

Background
The changes of shift handovers between medical staff are an important component of patient care, especially in emergency departments. A standardised approach is needed so as to avoid breakdown in continuity of care, delays in diagnosis, adverse outcomes and patient dissatisfaction.

Aim
To assess how closely the change in shift handovers follow the new Hunter New England Local Health District guidelines on clinical handover and determine which elements are performed well and which could be improved.

Methods
An audit tool based on the new guidelines was tested in a pilot study and then the tool was used to audit the morning and afternoon change of shifts.

Results
Of 318 handovers, over 90% gave the presenting complaint, the current situation and a plan or recommendation. Only about 60% included identifying names, age or mentioned any relevant patient background or medical history. Distracting noise from ED made it difficult to hear each patient’s information.

Conclusion
Shift change handovers missed key details such as name and a key recommendation is that handover should be done in a quiet meeting room to allow staff to clearly hear the patient’s details and management plans.
### Student Awards

#### Table of Submissions

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*Steven Alley, Kenneth Boldery, Ashley Everson, Sebastian Furneaux* |

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| **Appropriate Triage of Chest Pain: An analysis of the Australasian Triage Scale when applied to chest pain and its sensitivity and specificity for diagnosing acute myocardial infarct in a NSW rural referral hospital.**  
*Gabriella Penna, Bronwyn Hiles, Rhiannon Faulkner* |
| **A Root Cause Analysis: The Importance of ISBAR and Standardised Resuscitation Trolleys**  
*Scott Craythorn, Julia Bourke, Joel Cormie, Renju Cherian* |
| **Sepsis pathway compliance – a venture into health care improvement**  
*Maximillian Benness, Nicholas Frawley, Peter Michail, Nandini Singh* |
| **Optimising percutaneous coronary intervention for the treatment of ST-elevation myocardial infarction**  
*Myles Kwa, Lucinda Parsonage, Sam Phillips, Erin Pither, Angela Rajaratnam, Peter Ryan* |

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| **VTE Prophylaxis Improvement Project at Gosford Hospital**  
*Hoi Mun Tang, Wing Wai Tse, Raphael Na, Klasine Visscher, Kang Lim* |
| **An Analysis of Request Forms for CT scans at Gosford Hospital**  
*Paul Azzi, Milad Ghasemzadeh, Shrenik Hegde, Andrew Beshara, Yamini Yadav* |
| **ACER: Are Clinicians in Emergency Departments Recognising Sepsis: a retrospective data analysis of the NSW Health* Sepsis Kills program (Phase 1).**  
*Daniel Oliver, Emma Madams, Luke Anderson, Cedar Raw* |
| **Baring all on Dress Code: Assessing Adherence to Dress Code Policy and Contamination of Staff Clothing**  
*Fletcher Chariton, Belal Haniffa, Megan Johnson, Jasmine Somaiya, Madeline Wong* |
| **Smoking Cessation: Brief Interventions in the JHH/RNC**  
*Julie Lindemann, Nick Morgan, Alexandra Colman, Emily Dunn, James White, Angel Agarwal* |
| **Is Ceftriaxone being used as inappropriate surgical prophylaxis in non-complex cholecystectomies at a rural referral hospital? A retrospective audit of surgical antibiotic prophylaxis for laparoscopic cholecystectomies performed at Tamworth Rural Referral Hospital in 2013.**  
*Christian Brooks, Camilla King, Amanda Penberthy, Nicholas Evans* |
| **A descriptive and comparative study on the quality of X-Ray request forms received at Gosford and Wyong hospitals – an internal audit.**  
*Eugene Wong, Jake Crawford, Kendra Shen, Sankalpa Gurung, Andrew Li, Sam Der Sarkissian* |
| **Hand Hygiene Adherence: An Insight into Healthcare Worker Practices**  
*Katie Baker, Shalini Balendran, Rebecca Lindsay, Mrinal Naiker, Marzanah Parvin* |
| **A Retrospective Audit on Emergency Surgeries in John Hunter Hospital 2014: Delays and Cancellations.**  
*Anesheha Kaur Bhagat Singh, Krista Jiana Appadoo, Shalini Rajan, Vivian Yeo Xiao Yue* |
| **Retrospective Audit of Low-Molecular-Weight Heparin Administration to Outpatients Immobilised Secondary to Injury to the Lower Limb**  
*Andrew Dinihan, Rebecca Cohen, Jarrod Brady* |
| **A prospective audit of anaesthesia recovery indicators: post-operative nausea and vomiting requiring treatment in the recovery period and unplanned stay in the recovery room >2 hours for medical reasons.**  
*Simon Haron, Lachlan Frawley, Luke Vlismas, Andrew Cepak* |
| **Safety for Chest Pain Patients: an audit of patients at risk of acute coronary syndromes transferred from ED to ESSU in John Hunter Hospital**  
*Alex Bailie, Krystal Dinh, Kelly Eitzen, Anne-Marie Guider, Stephanie Wiltshire* |
| **Retrospective Audit of Procedural Sedation in the Emergency Department**  
*Christina Botfield, Alison Chandler, Jessica Henegan, Samantha Stott, Rachel Woodford* |
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