The Clinical Excellence Commission (CEC) is committed to making health care in NSW demonstrably better and safer for patients and a more rewarding workplace for health care workers. Achieving this will require effective and supportive clinical leadership at all levels of the system. Those in positions of leadership need to have both the skills and support to carry out their roles in a compassionate, safe and effective manner.

The importance of investing in clinical leadership programs has been noted in both the Statewide Garling report and the National Health and Hospitals Reform Commission report. Recognition of the link between leadership, patient safety and governance is also supported, where it is recognised that patients and staff are at the heart of health care.

Since the CEC’s Clinical Leadership Program was launched in 2007, over 1,000 participants have completed either the Executive (Modular) or Foundational (Statewide) format of the program.

An integral component of the Clinical Leadership Program is the undertaking of a clinical improvement project designed to improve patient safety and clinical quality. Participants are supported in the development of their clinical practice improvement through workshops which are provided by the CEC and through support from local clinical governance units.

In this book, we outline the projects undertaken by participants in the 2010/2011 Clinical Leadership Program. They address important quality improvement initiatives in a broad range of clinical areas, including, but not limited to: mental health; children with cancer; and care of patients in emergency departments. In addition to highlighting the benefits of the Clinical Leadership Program to the NSW health system, it is hoped the projects will encourage others to apply the findings or develop them further.

The results of many of these projects clearly demonstrate a strong commitment to clinical practice improvement through effective clinical leadership.

I am pleased to commend this book and encourage its use in the health system.

Professor Clifford Hughes, AO
Clinical Professor
Chief Executive Officer
The CEC is proud to present a summary of the projects undertaken by the 2010/2011 graduands of the Foundational (Statewide) and Executive (Modular) Clinical Leadership Programs. This is the fourth book of project summaries to be published by the CEC. The program continues to build a cohort of effective clinical leaders who progressively become the ‘critical mass’ needed for patient-centred system change.

The Clinical Leadership Program is offered in two different modes: Foundational and Executive. The Foundational program is multidisciplinary, targeting clinicians at a middle management level. It is delivered by local facilitators within the local health district. The Executive program targets senior clinician managers, and is delivered as six intensive modules in Sydney. Participants attend modules which focus on the personal and professional attributes of effective leaders.

Both programs require the identification of a clinical service challenge and completion of a clinical improvement project. This provides the opportunity for participants to apply the skills and learning they have gained in a real world context. It allows the strengthening of links between effective governance, core leadership competencies, a culture of safety and quality and continuous improvement.

The importance of the prospective design and redesign of health care processes to improve the quality and safety of patient care cannot be underestimated. Increasing cost of health care and an ageing population require new thinking and models of service delivery. We see effective leadership as the cornerstone of achieving ambitious improvement in health care systems.

Overview of CPI methodology

The model for the Plan, Do, Study, Act (PDSA) cycle was based on the work of Nolan, James, Berwick and Shewart and many other proponents of quality improvement. This diagrammatic representation of the process was developed by G. Rubin and B. Harrison for NSW Health (for the Clinical Practice Improvement Steering Group 2000.)
Clinical practice improvement (CPI) methodology is a key learning area of the program, as it provides a systematic approach which enables participants to undertake a clinical improvement project. The approach is based on the CPI methodology developed by Dr Brent James at Intermountain Health Care in the USA and has been adapted to the Australian clinical context. Participants are required to identify a problem in their clinical area which directly impacts on the quality and safety of patient care. In addition, participants are encouraged to engage with patients, relatives and consumers of health services in their projects.

Publication of this book has a twofold purpose. One is to present some of the clinical projects, their methods and outcomes; the other is to encourage the sharing and application of the projects more broadly throughout the health system.

In this book there is a list of projects undertaken by the 2010/2011 CLP participants. We congratulate them on their achievements and the broad scope of issues addressed. The projects chosen for inclusion in this book were selected due to the quality of the participants’ submissions to the CEC.

The CEC acknowledges the contribution and co-operation of the participants, their facilitators, managers, the clinical governance and clinical redesign units within local health districts, and the considerable expertise provided by an extensive external faculty of trainers. Our thanks to everyone for their ongoing involvement.

Bernie Harrison
Director, Clinical Leadership Development and Training, Clinical Excellence Commission

If you would like more information about the Clinical Leadership Program or further details about any of the projects please contact:

Clinical Excellence Commission
Locked Bag A4062
Sydney South NSW 1235
Ph: 02 9269 5500
Fax: 02 9269 5599
www.cec.health.nsw.gov.au
In 2010/2011 there were two Executive programs offered, with fifty-nine senior clinicians successfully completing the program.

All participants completed a clinical service challenge as part of the program, with a view to equipping them to act as patient safety advocates and to integrate health system improvement into their everyday clinical practice.

As indicated in the following pages, the clinical service challenges encompassed a broad array of topics, ranging from improvements in patient safety to specific clinical networks and organisational systems.

In order to graduate, participants were required to give a fifteen minute oral project summary to invited guests from the NSW health system and provide an abstract for assessment.

Participants of the 2010 (May intake) Executive (Modular) Clinical Leadership Program at the presentation day held in Sydney on Friday 1 April 2011.

Back row, left to right:
Gerald Chew, Ben Milne, Paul Fischer, Damien Limberger, Sean Kearns, Mark Joyce, John Gale, Andrew Dagg, Patrick Farrell, Adam Martin, Paul Spillane

Middle row, left to right:
Paul Clenaghan, David Mah, Helen Currow, Jennifer Bowen, William Pratt, Meegan Connors, Leanne Crittenden, Catherine O’Connor, Katherine Tucker, Pam Lane, Karen Munro, Heather Gough, Anne Capp, Kay Wright (CEC), Peter Wu

Front row, left to right:
Richard Cohn, Brian Pezzutti, Anna Chapman, Jillian Roberts, Brian McCaughan (CEC board), Bernie Harrison (CEC), Cliff Hughes (CEC), Margarett Terry, Megan Sherwood, Stephen Hampton, Cathy Vinters (CEC), Sharon McKay
The Foundational (Statewide) Program

The Foundational CLP is delivered within a local health district by local facilitators who are centrally managed and supported by the CEC. As a part of the program, participants identify a clinical service challenge and undertake an improvement project to improve patient safety and clinical quality within their area of work. A written and oral summary of projects is presented to district management, sponsors and CEC representatives, as part of the program.

Over 190 people successfully completed the 2010/2011 program, with all participants undertaking an individual or group improvement project. In addition, 12 rural health professionals completed the NSW Institute for Rural Clinical Services and Training “Clinical Team Leadership Program” which was modelled on the CLP and also included undertaking an improvement project.

As with previous years, improvement projects represented a broad range of topics, from specific clinical areas to broader system and workforce development initiatives. Support from program facilitators and CEC staff helped ensure that the scope and delivery of the projects were appropriate to the program goals and timeframes.

Sydney West Foundational (Statewide) Clinical Leadership Program Graduation

Back row, left to right:
Aliza Freeman (Drug and Alcohol Nepean), Jennifer McIntyre (Mental Health Blacktown), Samina Whale (Mental Health Nepean), Jacquie Hampton (Dietetics Nepean), Rhonda Beach (Mental Health Blacktown), Julie Longson (Diabetes Nepean), Sharon Chen (Infectious Diseases Westmead), Sharryn Byers (Neurosurgery Nepean).

Middle row, left to right:
Therese Ross (Ante-natal, Nepean), Matthew Rimmington (Theatres Nepean), Christine Sulfaro (Children’s ward Nepean), Linda Collins (Surgical Westmead), Dawn Hutley (OT Nepean), Jane-Louise Sinclair (Surgical Westmead), Vanessa Sands (BreastScreen Westmead), Michael Adamantidis (Mental Health Blacktown), Satish Mitter (ED, Blacktown/Westmead), Richard Tewson (Program Manager).

Front row, left to right:
Melanie Shier (Dietetics Blacktown), Jean Hawkins (Mental Health Blacktown), Rebecca Burrows (Drug and Alcohol Nepean), Johanna Dennis (Co-facilitator), Elaine Buggy (Executive Sponsor, Representative from Directorate of Nursing and Midwifery), Rachel Primrose (CEC).
Selected Project Summaries

2010/2011 Clinical Leadership Program – Selected Project Summaries

Strategies for Implementation and Evaluation of RCA Recommendations in Mental Health

Paul Clenaghan
NE Cluster Manager Mental Health
Sydney Local Health District

C-Clear documentation – Diabetes Educators and Insulin Dose Adjustment

Kristine Heels,
Nurse Manager Diabetes Clinical Service, Sydney Children's Hospitals Network, Westmead

Whose Care Plan Is It?

Jenelle Crowe,
Registered Nurse, Western NSW Local Health District

Reducing the Length of Stay in a Sub-acute Unit for Patients who are awaiting Long-term Residential Care

John Gale
Senior Nurse Manager,
Bourke Street Health Service,
Goulburn, Southern NSW
Local Health District

Griffith Base Hospital Doctors Hand Hygiene Project

Dr Damien Limberger
Executive Medical Director
Griffith Base Hospital
Murrumbidgee
Local Health District

DAWN – Drug and Alcohol Withdrawal Now: Improving Management for Pregnant Incarcerated Women

Dr Jill Roberts
A/ Clinical Director - Teaching and Operations, Drug & Alcohol Justice Health

Baby Breaths: Reducing Mechanical Ventilation in Premature Neonates

Dr Jennifer Bowen
Neonatologist,
Royal North Shore Hospital,
Northern Sydney
Local Health District

Shared-care Management of “Fever and Neutropenia” in Children with Cancer

A/Prof Richard Cohn
Head Clinical Oncology,
Sydney Children's Hospitals Network, Randwick

Oncology and Chemotherapy Closer to Home

Bronwyn Cosh
Clinical Nurse Manager
Hunter New England Local Health District
Physical and Mental Health

Michael Adamantidis
Team Leader Blacktown Mt Druitt Health Psychiatry (BMDH),
Rhonda Beach CNS Clozapine Coordinator & GP Liaison
Jennifer McIntyre RN
Blacktown Access and Assessment Mental Health Team (AAMHT)
Sydney West Local Health District

Decreasing Echo Reporting Time for Out-Patients

Dr Megan Sherwood,
Staff Specialist
Sydney Children’s Hospitals Network, Westmead

Improving Accuracy of Admitted Medical Patients Medications Charted in the Emergency Department

Susan Murtagh
Director of Pharmacy Belmont Hospital, Hunter New England Local Health District

Improving Patient Care and Outcomes within the Medical Assessment Unit (MAU) Medical Assessment Unit Emergency Department (MAUED)

Terena McIntosh
Nursing Unit Manager,
Medical Assessment Unit,
Royal North Shore Hospital
Northern Sydney Local Health District

PIVITAL Partnerships – Patient / Carer / Clinician

Meegan Connors
Clinical Lead Surgical Services Re-design, Orange Health Service
Western NSW Local Health District

Improving Emergency Department (ED) Processing Time

Dr David Mah
Director of Emergency Medicine Training
South Eastern Sydney Local Health District
Strategies for Implementation and Evaluation of RCA Recommendations in Mental Health

Paul Clenaghan
NE Cluster Manager Mental Health
Sydney Local Health District

Problem/Background

Investigations of critical incidents in NSW public health services frequently use a Root Cause Analysis (RCA) methodology, however, little is known about whether the findings and recommendations lead to improvement in service delivery.

A review of mental health RCAs in the Sydney Local Health District indicated that there were opportunities for improving the implementation of RCA recommendations. Critical incident findings are a powerful learning opportunity for mental health services.

A one-year review of critical incidents in the Sydney Local Health District (August 2009 – August 2010) identified that 24 of the 30 completed RCAs found cases of death by suicide, two found cases of homicide and a further four were identified as other critical incidents.

50 per cent of the 30 RCAs reviewed had no root causes or system improvements identified¹, seven (23%) identified root causes, and there were a total 23 system improvement recommendations.

This review identified problems with implementing recommendations from RCA findings, with 16 of the 30 recommendations overdue for evaluation and only four having been recorded as implemented in the previous 12 months.

Aim

To develop strategies for the effective implementation and evaluation of RCA recommendations in a mental health service.

Diagnosis 1: Survey of Senior Clinical Managers

A thematic analysis of responses to a survey of senior clinical managers (N=19) identified that recommendations were not easy to implement. Managers identified problems with methodology, resourcing and considered the expectations to be very high. Managers also reported that RCA findings were not communicated in a useful format, were poorly distributed and had unreasonable timeframes.

Diagnosis 2: RCA timeline

The key stage of communicating and implementing RCA recommendations occurs some two months after the incident. The drive to improve services based on the findings from a RCA may diminish over time.

Diagnosis 3: RCA methodology and study where n=1

RCAs can be criticised for drawing conclusions from a study where n=1. Furthermore, the review of someone who commits suicide is complex and the RCA team considers critical clinical, personal and background issues, some of which often remain unknown.

Changes made

Eight strategies were developed to improve the implementation of RCA recommendations. These are described below.

¹ A root cause is considered to be directly related to the critical incident outcome. Systems improvements are opportunities unrelated to the root causes/contributing factors and are findings noted during the course of the investigation which do not have a bearing on the outcome.
2. Launch of major projects to
address major themes (handover,
review of community mental
health services)

The development of major
projects (based on themes) has
enabled recommendations to be
implemented. For example, over
the past three years, there have
been 26 recommendations from
RCAs which relate to handover
or discharge processes. This
represents 30 per cent of the
recommendations. A handover
project was launched one year
ago and significant resources
allocated.

3. Communication strategies
A monthly newsletter was
developed which synthesised
information. RCA reports were
posted on the intranet for more
detailed information.

4. Review Terms of Reference
Implementation and evaluation
of RCA recommendations
was established as a standing
agenda item in serious incident
review meetings.

5. Database
A database of RCAs was
developed which provided a
framework for tracking and
reporting recommendations.

6. The recommendation: content,
leadership and priority
The specific content of
recommendations was reviewed
with greater scrutiny. This
included who would be allocated
to lead implementation and the
organisational impact.

7. Template for evaluation
A standardised template was
developed for reporting the
evaluation of recommendations.

8. Recognising different levels
of reporting needs

Identification of what needs to
be reported up and what needs
to reported to clinical teams is
emerging as a key area.

Measurement/process
measures

The above actions and processes
are enabling more effective and
timely implementation of RCA
recommendations and fewer are
overdue (see table below).

<table>
<thead>
<tr>
<th>Date</th>
<th>Overdue</th>
<th>Completed in previous 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-10</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Mar-11</td>
<td>6</td>
<td>14</td>
</tr>
</tbody>
</table>

Plans to sustain or
spread change

Recognising that RCAs provide
an important learning opportunity
is the first stage of this project.
Good clinical governance, project
management and analysis of
RCA themes will drive the cycle
of continually improving service
delivery, based on RCA learnings.

### Theme RCA Recommendation
August 2009 – August 2010

<table>
<thead>
<tr>
<th>Theme</th>
<th>RCA Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handover/Discharge</td>
<td>9</td>
</tr>
<tr>
<td>Risk</td>
<td>4</td>
</tr>
<tr>
<td>Family inclusion</td>
<td>3</td>
</tr>
<tr>
<td>GP inclusion</td>
<td>1</td>
</tr>
<tr>
<td>Missed appointments</td>
<td>1</td>
</tr>
<tr>
<td>Clinical review/case conference</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
</tr>
</tbody>
</table>
C-Clear documentation – diabetes educators and insulin dose adjustment

Kristine Heels
Nurse Manager Diabetes Clinical Service, Sydney Children’s Hospitals Network, Westmead

Problem/Background
Diabetes Educators (DEs) at The Children’s Hospital Westmead (CHW) spend a large percentage of their day on the phone talking primarily to families of children with type 1 diabetes. Many of these calls involve discussion and suggestions about changes to insulin doses. This team of nurses is a unique group nationally, as very few nurses directly prescribe dose titration of any form of medication.

The diabetes educators at CHW are required to document each phone call outlining the management decisions suggested and record the amount of time spent on each occasion of service (OOS). These records are essential to meet our legal requirements and ensure patient safety, as well as being a method by which we can communicate effectively with the other team members. They also allow us a system through which we can potentially assess our patient load and therefore make recommendations for our staff requirements.

Traditionally, the notes recording details of the phone calls have been kept on ‘daily running sheets’ which are passed around to team members. This project was established to create an electronic-based documentation system for all insulin advice given by the diabetes educators.

Aim
The aim of the project was to ensure that 100 per cent of phone calls taken by the diabetes educators regarding insulin adjustment are documented in Powerchart by March 2011.

Problem identified
Historically a paper ‘daily’ sheet was kept by DEs to document insulin adjustment, with paper copies kept for seven years within the department. This created a storage problem in the area. The process for using the sheets meant they were passed between team members, often causing their misplacement or non-return and resulting in duplication of documentation and poor communication of any changes made.

As a result of these inefficiencies of practice, families were often required to repeat information provision and requests. An additional serious consequence was the poor communication among the team who were providing the advice to families regarding the doses to be given.

A review of the electronic records of 15 newly diagnosed children with type 1 diabetes, admitted between January and March 2010 was undertaken and involved the review of 210 potentially documented OOS, of which only 22 OOS were actually documented.

At the beginning of the project, the team looked for evidence of electronic documentation of daily calls during the months of January, February and March 2010, and found 10.4 per cent of daily calls recorded electronically.
Changes made
Diabetes educators met with the IT Department to describe the problem and discuss what changes could be made to capture electronically the number and content of OOS in an easy-to-use manner. A database entry system was designed using Powerchart software. Headsets were purchased for use in facilitating entry of data by DEs while they are talking on the phone, and a PC was installed in Diabetes day care. Training of Diabetes team members in use of the new system was carried out.
Opportunity remains to work with IT more closely on specific projects relating to documentation and statistics collection in the future.

Measurement/process measures
A review of the electronic records of 15 newly diagnosed children with type 1 diabetes admitted between October and December 2010 was undertaken and involved the review of 210 potential documented OOS. This found 87 OOS were documented.
At the end of the project, the team looked for evidence of electronic documentation of daily calls during the months of October, November and December 2010 and found 41.4 per cent of daily calls recorded electronically; a substantial increase from the earlier review.
It is anticipated that accurate documentation of doses and the explanations as to why dose decisions have been made may lead to improvement in child safety, team communication and junior staff training.
In addition, the project has made other measurable achievements, including:
• Improved communication among the Diabetes team
• More efficient use of staff time and resources
• Reduction in instances of families having to repeat days’ worth of information that previously may not have been documented and traceable
• The project may also work as a model by influencing how other CHW departments document their phone communications when dealing with medication dose changes.

Plans to sustain change
Plans to sustain the changes made through the project cover the three elements of monitoring, documenting, and information sharing.
The project’s changes will be sustained through ongoing monitoring, using similar reviews as undertaken in the project, to monitor OOS documentation processes biannually. Regular team meetings and any required meetings with IT staff will monitor the success and currency of the software and address any issues that arise in its use over time.
Reporting back on the successes of the new systems to the Diabetes team provides monitoring of their performance and benchmarks for practice. Ongoing monitoring of the processes will allow new initiatives to be identified and implemented, in response to any issues arising from the monitoring processes.
Documentation of the new policies and procedures of the OOS recording system will provide the monitoring blueprint and will assist in ensuring standardised practice, so processes can be accurately replicated, even if there is staff turnover.
Information sharing will occur through a system of ongoing training and education of Diabetes team staff. In addition, the sharing of project processes and achievements with others in the regular formal meetings associated with the Diabetes team’s work will assist to sustain change and perhaps promote further change.
Whose Care Plan Is It?

Jenelle Crowe
Registered Nurse
Western NSW Local Health District

Problem/Background
The concept of client-guided recovery in the treatment and management of mental illness has been gaining momentum for several years. There has been a gradual shift in the emphasis of ‘clinical/medical’ based recovery, towards recovery that is more ‘personal or client defined’.

Evidence based on the ‘lived experience’ shows that providing clients with the support and opportunities to achieve in the area/s that they identify as important, assists in their recovery processes.

The care plan is a tool that can be easily employed to engage the consumer in their own care and facilitate their identification of recovery goals. Clinical care is routinely documented on care plans, but client-defined goals are often lacking.

Aim
The aim of the project is to improve consumer participation and recovery orientation in care planning by incorporating consumer-identified goals. The aim is for 80 per cent of consumers accessing Endeavour House Residential Program to have documented evidence of a personal goal in their care plan within the next six months.

Problem Identified
An audit of care plans of residential clients from Satellite Housing Integrated Programmed Support (SHIPS) revealed that the majority of care plans were addressing nursing/medical defined clinical goals, while missing the opportunity to engage clients in nominating issues that they identified as impeding their recovery.

While all staff and clients at Endeavour House acknowledged the importance of inclusion of client-defined goals in care planning, the audit of care plans revealed that although all clients had signed their care plans, only one had an identified client goal included.

Changes made
Education on the principles of recovery-orientated mental health practice was offered to staff. This is available on an ongoing basis to ensure all staff become familiar with the concepts of client-directed recovery.

Documentation of a client-identified goal on each care plan was made a priority.

Case managers were encouraged to consult with and support clients as they explored their recovery journeys, identifying what they saw as important for their recovery.

An identified client-directed goal was then developed and incorporated into the care plan. Examples of goals identified include: securing affordable and appropriate housing; completion of a TAFE course; and an overseas trip.

Measurement/Process Measures
A base-line audit of all residential client care plans was conducted, followed by regular monthly audits. It looked for evidence of client involvement in the development of an identified personal goal.

Six weeks into the project 6 per cent of files contained a client-identified goal with the number growing to 50 per cent at the six month mark. An audit conducted two months later showed that 82 per cent of care plans had client-identified goals.

Plans to Sustain Change
The project has been well received by the management, staff and clients of the SHIPS program. All have indicated that they can see the value of inclusion of a recovery-focused client-defined goal in the care plan and all are supportive of continuing this focus.

New staff will be offered education on recovery principles and the importance of client-defined goals in all care plans, as a means of informing recovery-based care.

Expansion of the project has already commenced at two other SHIPS residential facilities (Kallara and Tallowood), with staff and residential clients enthusiastically embracing the idea. Plans are now underway to educate and encourage ambulatory clients receiving SHIPS follow-up to identify a personal recovery-focused goal.
Reducing Length of Stay in a Sub-acute Unit for Patients awaiting Long-term Residential Care

John Gale
Senior Nurse Manager
Bourke Street Health Service
Goulburn, Southern NSW
Local Health District

Problem/Background

Patients who have completed their rehabilitation, but are unable to return home due to ongoing physical challenges, often require admission into long-term care. The process for accessing a residential care facility can be drawn out and while the patient waits for all the requirements to be met it is imperative that his or her physical status is maintained.

Following the impact of a serious patient fall, a root cause analysis investigation was conducted with recommendations. Fundamental to addressing these recommendations was a raft of suggestions which focused on addressing two basic issues.

• Delay in discharge – which can cause a sub-acute exit block, where, due to resource allocation patients may de-condition while they await a bed.

• Communication and co-operation across the range of teams involved in co-ordinating a patient’s discharge to a residential care facility (RCF).

Aim

To reduce the length of stay by 20 per cent within six months for patients who are awaiting long-term residential care.

Problem identified

Analysis by key stakeholders at a series of strata identified that a number of vital elements needed to be addressed.

• A deficit in clinical framework had caused a lack of focus and drive within the specialty care team, leading to an inadequate model of care and a fragmented approach to case co-ordination and care planning.

• Communication lines had become blurred and this had impeded a clear delineation of care co-ordination of the patient.

• The framework which supported the co-ordination of patients moving from the sub-acute facility and being admitted into RCFs required attention, so that the length of stay and overall number of patients awaiting a bed in a RCF was kept to a minimum.

Changes made

A multidisciplinary case management model was established in the Sub-acute Unit to maintain a co-ordinated approach to patient-focused care, through the engagement of visiting medical officers, allied health & nursing services.

This process included:

• a daily meeting of the community-based teams, which include the Acute to Aged Related Care (AARC) nurse; representatives from the Aged Care Assessment Team (ACAT); representatives from nursing; discharge planners - with other teams invited as required.

• a weekly multidisciplinary case conference specifically to discuss the health maintenance strategies and provide a case review system for patients who are awaiting admission into a residential care facility. Development of terms of reference for this conference that clearly emphasise the role of each discipline, allied health, nursing and visiting medical officers, in successfully managing the care of these patients.

• a weekly length-of-stay meeting between a member of the facility executive, the nursing unit manager and the AARC nurse to specifically discuss each patient’s current length of stay, to monitor the steps to successfully discharge the patient into a RCF and explore opportunities to overcome barriers which may be impeding their discharge.
Clinical Leadership Program

- Enhancing the communication with family members by conducting timely and routine family meetings, that may or may not include the patient, to ensure families are informed of their obligations for a successful discharge to a RCF.

**Measurement/process measures**

Through initiatives introduced in this project we achieved:

- **Average Length of Stay:**
  - 2008/2009 = 44 days
  - 2009/2010 = 45 days

Change made July 2010:

- **Average Length of Stay:**
  - 2010/11 = 38 days

This data is presented graphically in Figure 1 (below).

**Plans to sustain or spread change.**

- The meetings introduced through this project have become part of the normal practice for the clinical framework of care of patients who are awaiting admission to residential aged care facilities.

- The length of stay for each patient is independently monitored weekly and reports are produced to review the results.

- A feedback mechanism has been simultaneously introduced which encourages families to provide written comments on their hospital experience.

- The processes incorporate Essentials of Care Program Principles.

- Through this process we have created a seamless model which promotes communication and co-operation across the range of teams involved in co-ordinating a patient’s discharge to a residential care facility.

*Figure 1. Average length of stay 2008-2010*
Griffith Base Hospital Doctors Hand Hygiene

Dr Damien Limberger
Executive Medical Director
Griffith Base Hospital
Murrumbidgee Local Health District

Problem/Background
At Griffith Base Hospital the hand hygiene compliance rate for doctors was 41.5 per cent in the period August to November 2009. This was significantly lower than the nursing hand hygiene compliance rate of 62.8 per cent. National trends for hand hygiene compliance consistently show that doctors underperform in this area compared with other health professions.

Aim
The aim of the project was to improve doctors’ hand hygiene compliance at Griffith Base Hospital by 50 per cent to match nursing compliance.

Problem Identified
A multidisciplinary working party was formed to brainstorm reasons for underperformance of doctors’ hand hygiene compliance. Doctors had not been engaged in the implementation of the Hand Hygiene Initiative. General observations suggested that doctors at Griffith Base Hospital may not even be aware of the Hand Hygiene Initiative.

A survey of the core senior clinicians was undertaken to assess their existing level of knowledge and awareness of hand hygiene.

Figure 1. Doctor and patient hand hygiene interactions

Three out of eleven doctors surveyed had heard of the ‘5 Moments of Hand Hygiene’ and one knew what all five moments were.

Flow diagram analysis (see Figure 1) was undertaken to identify key opportunities to improve hand hygiene product accessibility and
Figure 2. Potential causes of poor hand hygiene

A cause-and-effect diagram was constructed to identify potential causes for the poor compliance (see Figure 2).

The key areas identified, in order of importance, were: education; leadership; developing a hand hygiene safety culture; patient contribution; and individual doctor factors.

Using a voting system, reasons that hand hygiene does not always take place were collected and a pareto chart was produced which prioritised results (see Figure 3).

Changes made

A series of PDSA cycles was undertaken (see Figure 4). The hand hygiene audit results were used to monitor outcomes. The first PDSA cycle aimed to raise general awareness of the Hand Hygiene Initiative, health care associated infections, evidence for hand hygiene, the ‘5 Moments of Hand Hygiene’ and the audit process. This was delivered as a grand round presentation.
The next PDSA cycle targeted JMOs and medical students. A hand hygiene tutorial was developed and incorporated into the compulsory JMO teaching program early in each JMO rotation.

The next PDSA cycle aimed to increase awareness and to encourage leadership from the senior clinicians. This involved a successful collaboration between the Clinical Excellence Commission, Greater Southern Area Health Service and the Murrumbidgee Division of General Practice to host two presentations. One was for the hospital executive and the second for senior clinicians, including GPs. The guest speaker was infectious diseases physician, Dr Craig Boutlis, who provided expert knowledge and motivation for leadership and change.

The following PDSA cycle implemented a hand hygiene stewardship program to reinforce compliance, leadership and change of work culture.

**Measurement/process measures**

The doctors at Griffith Base Hospital increased their hand hygiene compliance to 60.9 per cent (see Table 1). A number of senior clinicians have since become leaders in hand hygiene compliance and role models for other staff.

**Plans to sustain or spread change**

Further improvement strategies will be required to continue to improve hand hygiene compliance at Griffith Base Hospital. The interventions already implemented will continue on a regular basis.

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Due to the large number of locum doctors, hand hygiene product and the ‘5 Moments of Hand Hygiene’ posters have been installed into the locum and JMO accommodation to reinforce the message that hand hygiene is part of the culture at Griffith Base Hospital.

The next phase will be targeted at increasing patient participation by involving the local health advisory committee to join the working party.

**Table 1. Hand hygiene compliance by audit period**

<table>
<thead>
<tr>
<th>Audit Period</th>
<th>GBH Total %</th>
<th>Doctor %</th>
<th>Nurse %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-Nov 2009</td>
<td>50.39</td>
<td>41.51</td>
<td>62.84</td>
</tr>
<tr>
<td>Dec-Mar 2010</td>
<td>54.17</td>
<td>44.25</td>
<td>68.66</td>
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<tr>
<td>Apr-Jul 2010</td>
<td>45.93</td>
<td>32.58</td>
<td>57.62</td>
</tr>
<tr>
<td>Aug-Nov 2010</td>
<td>54.22</td>
<td>44.49</td>
<td>59.04</td>
</tr>
<tr>
<td>Dec-Mar 2011</td>
<td>63.60</td>
<td>60.90</td>
<td>67.06</td>
</tr>
</tbody>
</table>

**Figure 4. Hand hygiene percentage compliance**
Clinical Leadership Program

DAWN – Drug and Alcohol Withdrawal Now: Improving Management for Pregnant Incarcerated Women

Dr Jill Roberts
A/ Clinical Director
Teaching and Operations
Drug & Alcohol, Justice Health

Problem/Background

Women entering legal custody in NSW have a very high incidence of drug and alcohol use, with 40 per cent drinking at harmful/hazardous levels and 78 per cent using illicit drugs (Justice Health Inmate Health Survey 2009). Once incarcerated, these women are at high risk of drug and alcohol (D&A) withdrawal. Women with drug and alcohol issues who are pregnant need early intervention to decrease risk of an adverse pregnancy outcome. Prior to this project, there was no standardised protocol for management of these women.

Aim

The aim of the project was that within six months, 100 per cent of newly incarcerated adult women identified as pregnant and at risk of drug and alcohol withdrawal, would have a management plan commenced and implemented within 12 hours of being taken into custody.

Problem identified

A clinical audit was conducted on all pregnant women over the age of 18 who entered legal custody in NSW between October and December 2010. Of the 11 new pregnant patients identified, nine had drug and alcohol issues. None had been receiving any antenatal care prior to their incarceration. The audit revealed there was no standardised process of care. Six patients had some management plan in place, but there was wide variation in care that was site dependent and/or clinician dependent. Two patients were never referred to the Drug & Alcohol Medical Officer. These are a group of women with high-risk pregnancies who are not engaging with health services in the community.

The multi-disciplinary project team brainstormed the extent of the problem, potential causes (see Figure 1), the improvements needed and potential solutions.

Changes made

Widespread consultation was held and included the service directors and clinical directors in primary and women’s health, clinical and nursing operations, rural and remote and the Adult Drug Court Program. The project gained widespread support. Consultation was also held with the team of addiction medicine staff specialists who provide an on-call service 24 hours a day for seven days a week. The consultation process resulted in agreement being reached regarding management protocols.

Multiple strategies of communication were used with all nurses, to ensure they were aware that they are required to contact an addiction medicine staff specialist within four hours of patient assessment to commence a patient management plan. Local site process flow charts were developed to ensure appropriate placement of patients, level of observations required, communication with the treating doctor and clinical handover. Emphasis was placed on improved documentation and referral processes. The pregnant women were therefore engaged and streamlined into treatment rapidly as an urgent priority. Early involvement with an addictions staff specialist reduces the risk of adverse pregnancy outcomes.

Measurement/process measures

An audit undertaken between October and December 2010, showed that of the nine new pregnant women with D&A issues, there were six cases for which a doctor was contacted within 12 hours with some management plan in place, but most plans were not very specific. Three patients were not discussed with a doctor within 12 hours of their arrival into custody.
A repeat audit was planned for the January to March 2011 period to evaluate compliance with the management plan and to examine the medical records regarding any issues around non-compliance.

The repeat audit was conducted between January and March 2011 and seven new pregnant women with D&A issues were identified. Of these, five were discussed with a doctor within 12 hours and had a specific management plan in place. Two patients were not discussed with a doctor within 12 hours. In this quarter, all pregnant women with drug dependency issues were discussed with a doctor within the benchmark 12 hours and the two where the doctor was not contacted were using drugs but were not dependent. Notwithstanding this, it was the aim of the project that a doctor would be contacted about these women as well.

There is increased awareness by clinical staff of the importance of early intervention and improved and standardised protocols of management. There is improved clinical handover in both nursing and medical contexts and improved continuity of care. Clinically, withdrawal is closely managed with improved early entry into long-term treatment. Many of the women concerned may only be in custody for brief periods of time and pregnancy is often a strong motivation for women to change their drug use. The new process improves opportunities for brief interventions and patient education about the risks of drug use in pregnancy.

Plans to sustain or spread change

There will be ongoing audits, every three months, with opportunities for Plan, Do, Study, Act (PDSA) cycles. There are plans to broaden the project to improve other aspects of drug and alcohol management in high-risk pregnant women. In May 2011, this project was presented at Grand Rounds, Westmead Hospital and has been accepted for presentation at the Australasian Professional Society on Alcohol and other Drugs Conference in November 2011.
Baby Breaths: Reducing Mechanical Ventilation in Premature Neonates

Dr Jennifer Bowen
Neonatologist
Royal North Shore Hospital
Northern Sydney Local Health District

Problem/Background

Premature neonates require support of their breathing in order to transition to ex-utero life. Such support may be provided as mechanical ventilation via an endotracheal tube and in some babies, through less invasive respiratory support, such as Continuous Positive Airway Pressure (CPAP). Prolonged ventilation, while a life-saving measure, is associated with increased risk of adverse outcomes, such as chronic lung disease and increased intensive care costs. Through benchmarking data, a longer duration of ventilation and higher incidence of chronic lung disease for premature neonates admitted to RNSH Neonatal Intensive Care Unit (NICU) was identified, compared with some other neonatal units in NSW.

Aim

The aim of the project was to decrease the number of mechanical ventilation days in premature neonates born before 32 weeks gestation, who were admitted to the RNSH Neonatal Intensive Care Unit by 20 per cent within 12 months.

Problem identified

Clinicians providing care to neonates undertook multidisciplinary brainstorming sessions, literature review, review of practice in other NICUs, and a nursing focus group was established to identify ways of improving management of neonates receiving both invasive mechanical ventilation and non-invasive respiratory support (CPAP).

Changes made

Changes were made in two phases.

• Phase 1 took place from July 2008 to Dec 2009, during which period a number of process changes were made to respiratory procedures, including introduction of “bubble” CPAP, introduction of brief intubation for early prophylactic surfactant delivery (INSURE procedure) and a policy to commence CPAP, in preference to mechanical ventilation support for initial respiratory support, when feasible.

Measurement of outcomes showed that the process changes were achieved, with an increase in use of prophylactic surfactant from 75 to 97 per cent and a decrease in mechanical ventilation in the first hour of life from 83 to 56 per cent in neonates <29 weeks gestation. However, there was no significant change in average duration of mechanical ventilation or chronic lung disease for neonates <32 weeks gestation compared with baseline measures from 2007/08 (average ventilation days: 2007/08: 4.3 ± 2.5 days, 2008/09: 4.5 ± 2.3 days).

• Phase 2 occurred in 2010, where the focus was on the methods of delivering optimum care, rather than the type of procedure delivered. Changes to CPAP management aimed to maintain continuous CPAP to prevent de-recruitment of lung alveoli, in order to decrease the likelihood of a baby needing to be re-ventilated. Policy changes included introduction of a CPAP prong change procedure, which involved two staff members maintaining continuous CPAP, until it could be completely ceased, rather than reducing CPAP through a gradual weaning process.

Education sessions and case review sessions were implemented, with a focus on ways to provide optimum CPAP and respiratory care.
Selected Project Summaries

**Measurement/process measures**

Average ventilation days and the proportion of neonates who required ventilation were measured for the whole group (<32 weeks gestation) and for two gestational age range sub-groups.

**Results:** Those neonates at <32 weeks gestation (n=434) had a decrease in average number of ventilation days by 24 per cent from the baseline of 4.2 ± 2.5 days to 3.2 ± 1.8 days in Phase 2 of the project (see Figure 1).

Results for two sub-groups of neonates are shown below (and see Figure 2).

**Neonates between 28 and 31 weeks gestation (n=302):**

- Decreased proportion of neonates ventilated:
  - Baseline: 42%
  - Phase 1: 36%
  - Phase 2: 26% (p=0.041)
- No change in ventilation days (average 1-2 days)

**Neonates at <28 weeks gestation (n=132):**

- Decrease average ventilation days:
  - Baseline: 12.5 days
  - Phase 1: 10 days
  - Phase 2: 7.9 days
- No change in proportion ventilated (85-88%)

**Plans to sustain or spread change**

To sustain change in practice, a nurses focus group, ongoing education program and regular case reviews of neonates requiring prolonged respiratory support, have been established.

There will be increasing collaboration with other NSW and ACT neonatal intensive care units to produce a centralised NICU database to collect and maintain data for ongoing comparative purposes and review of continuing effectiveness of the new measures.

The NICUS website was launched in November 2010 to share information.

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"Leadership and learning are indispensable to each other"  
John F. Kennedy
Shared-care management of “Fever and Neutropenia” in children with cancer

A/Prof Richard Cohn
Head Clinical Oncology
Sydney Children’s Hospitals Network, Randwick

Problem/Background

Fever and neutropenia in the child on treatment for cancer is a potential medical emergency. Physical signs may be muted due to paucity of inflammatory cells. Death during fever and neutropenia is still 1 per cent despite early institution of empiric antibiotic therapy. Each hour of delay is associated with decreased survival. The broader goal of this project was to look at models of care for rural and remote childhood cancer patients, which would allow care closer to home without compromising quality and safety. When patients require administration of chemotherapy, travel to a tertiary centre is often unavoidable.

Aim

To reduce the time to initiation of antibiotic therapy to 60 minutes in 100 per cent of paediatric cancer patients presenting with fever and neutropenia in both metropolitan and rural/regional hospitals within six months.

Problem identified

A study, undertaken in 2003, by a combined multidisciplinary team from Oncology and the Emergency Department (ED) at Sydney Children’s Hospital documented a time to antibiotic administration of 3 hours and 15 minutes in febrile neutropenic patients. Analysis of the process identified a number of decision points which caused delays. To combat this, a consensus algorithm was developed, which mandated triage to category 3, followed by nurse-initiated accessing of the central line, and blood being sent for testing.

Following the new process, initial antibiotic administration occurs as soon as the patient is reviewed by the ED officer, without needing consultation with the oncologist. Once the blood results are available, the oncologist is contacted and further treatment confirmed. The change in process was supported by staff education and encouragement of parent advocacy, with a parent-held record issued with an alert card to draw attention to what needed to be done. Using the algorithm, time to administration of antibiotics was reduced to 1 hour and 15 minutes in the tertiary centre. The time was considerably longer (in some instances greater than 8 hours and in some, not given at all) in the rural and remote centres with which care is shared for close to 50 per cent of the patients.

Changes made

Initiatives were introduced in conjunction with and support from all stakeholders. These were:

- Intensified education to ‘upskill’ staff to manage children with fever and neutropenia
- Provision of mannequins for training in managing venous access devices
- Development of a teaching video about managing venous access devices.

Measurement/process measures

The principle of improving care for paediatric oncology patients presenting in rural areas was supported by all stakeholders, multidisciplinary health professionals and parent...
consumers. The algorithm of care is supported by the oncologists at the tertiary referral centre. Median time to the first dose of antibiotics for children febrile and neutropenic with cancer in the tertiary hospital are shown in Figure 2.

Rural and regional health care practitioners involved in the project have endorsed the approach and have shown enthusiasm to ‘upskill’ staff and provide quality care closer to home for patients. Median time to the first dose of antibiotics for children febrile and neutropenic with cancer in the index community hospital are shown in Figure 3.

Many centres have provided isolation facilities for patients, a previous source of concern for parents and staff alike. When patients are not in isolation, they are with everyone else in the waiting room and exposed to multiple ailments.

The tertiary centre has undertaken ongoing education with a recognition that staff turnover resulting in loss of expertise for accessing central venous access devices is an ongoing risk to this approach. Tools to consolidate the educational intervention are being rolled out. These include mannequins for simulation, a teaching video, alert cards and patient-held records (see Figure 4). One regional centre has allocated philanthropic funds to support the purchase of mannequins, updating of the teaching video and facilitation of education.

 planted to sustain or spread change

Ongoing auditing of the management of ‘fever and neutropenia’ patients has been instituted. It is a regular agenda item when oncology outreach nurses visit rural sites and ongoing scheduled education is in place with further roll-out of teaching resources underway. Work is in progress to achieve a
A uniform algorithm for ‘fever and neutropenia’ in children across NSW. Unique solutions, such as teaching parents to access central venous access devices and involving general practitioners and nurse unit managers of rural clinics, in the absence of other resources, has widened the expertise to allow more treatment closer to home. This approach has allowed administration of a first dose of antibiotics where there are no facilities for admission, followed by the safe transfer of the patient to a larger rural centre.

**Goals/Anticipated results of implementation**

The identified goals of the projects and results of its implementation include:

- Improved patient care
- Family satisfaction with the local hospital
  - Confidence in the hospital
  - Benefits of treatment closer to home
  - Financial savings from costs of travel to the tertiary referral centre
- Regional and rural hospital staff satisfaction
  - Confidence
  - Improved skill set
  - Consumer satisfaction
- Tertiary hospital benefits
  - Decreased bed block

**Figure 3. Median Time to First Dose Antibiotics**

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Baseline 1</th>
<th>6 months post intervention</th>
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<td>0</td>
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</table>

**Algorithm introduced**

**Median Time to First Dose Antibiotics**

**Figure 4. Mannequin and patient-held record**

**Acknowledgements**

In the development and support of this project, the following teams and individuals are acknowledged:

- The multidisciplinary project team
- The CCCBD, SCH MDT
- The Emergency Department, SCH
- Infectious Diseases Department, SCH
- The Behavioural Sciences Unit, CCCBD, SCH
- Medical and nursing staff, regional and rural NSW
- Wollongong Paediatric Service
- Patients and Carers, CCCBD, SCH
**Oncology and Chemotherapy Closer to Home**

**Bronwyn Cosh**
**Clinical Nurse Manager**
**Hunter New England Local Health District**

**Problem/Background**
Historically there has been no oncology service available in Moree, and only a limited chemotherapy service.

The monthly visit of the Moree person living with cancer to the oncologist in Tamworth entailed a 550km road trip and usually a day off work for the carer. These were both financial and physical burdens. These trips occurred at times when the patient was debilitated and vulnerable and thus caused much anguish and physical exhaustion.

With the appointment of an oncologist at Tamworth Cancer Clinics, the opportunity arose to establish an outreach oncology clinic at Moree and thereby enable an increase in the number of cancer patients who could access their treatments locally.

**Aim**
To establish an oncology service and increase chemotherapy treatments delivered at Moree District Health Service. The provision of these services was to increase access and improve the treatment experience of the Moree person living with cancer.

**Problem identified**
Patient stories brought to light the plight of the person living with cancer and requiring regular assessment and treatments. It is estimated that ‘Bob’ had to travel for eight hours on 18 days (a total of 13,008 km) to access services, prior to the clinics becoming operational in Moree. Having to travel long distances for oncology and chemotherapy when debilitated has a significant impact on the ability to recuperate, especially in the latter stage of the disease process.

The need for carers to take time off work to transport the patient to appointments adds financial and work-related stressors to the equation.

Chemotherapy services were available in Moree, but due to patients requiring assessment by an oncologist prior to treatment, many were not eligible to receive their chemotherapy treatment in Moree.

Patient stories highlighted the time and distance travelled to access oncology services.

By having an oncology clinic and chemotherapy service located in Moree, there would be access to a local safe and efficient service. A local service would allow for a more positive patient experience for the person living with cancer.

**Changes made**
An outreach oncology service was commenced to operate one day per month in Moree.

An outreach chemotherapy service was enhanced to operate two days per week in Moree.

An extra registered nurse was trained to increase the delivery of chemotherapy treatments. Administration staff were trained to support clinical staff (ARIA program).

A pre-clinic patient survey was conducted to establish the difference for patients in the circumstances of their clinic visits. The questions in the survey were:

- How many kilometres did you have to travel to visit an oncologist prior to today?
- How much time will you save by not having to travel for this appointment?
- What was the financial cost associated with travelling to Tamworth?
- What impact did this have on your family?
- Are you comfortable being seen in Moree rather than in Tamworth?
- Will you be comfortable if you need to have chemotherapy in Moree?

**Measurement/process measures**
Figure 1 shows the increases in the provision of chemotherapy services to patients in Moree from January 2009 to March 2011, as a result of the changes made to clinic service availability.

Figure 2 shows the pattern of oncology reviews conducted at Moree from March 2010 to May 2011, and the marked increase in the number of reviews since the project was implemented.

There was no service available in May and July, due to the oncologist taking leave.
An evaluation was conducted six months after commencement of the oncology service, using a patient survey. The results indicated:

- Patients very pleased to have local service
- Patients would like a dedicated chemotherapy room rather than sharing of renal resources
- The clinic requires more resources such as its own infusion pumps
- Not having to travel to Tamworth has reduced financial strain on patients
- Not having to travel to Tamworth means family no longer need to take the day off work to accompany patients.

**Plans to sustain or spread change**

Moree Oncology Clinic will continue to operate in its present form one day per month in 2011.

Due to expansion of the Moree renal unit from three to six days per week (the chemotherapy clinic was held in renal unit two days per week), the chemotherapy clinic will need to relocate. This has given Moree District Health Service the opportunity to review all cancer services. Plans for 2011 are underway to establish a specific area to house oncology, chemotherapy, and palliative services together.

Oncology and chemotherapy services are well supported by the community, who are keen to support further services.
Linking physical and mental health

Michael Adamantidis
Team Leader Blacktown Mt Druitt Health Psychiatry (BMDH)

Rhonda Beach CNS
Clozapine Coordinator & GP Liaison

Jennifer McIntyre RN
Blacktown Access and Assessment Mental Health Team (AAMHT)
Sydney West Local Health District

Problem/Background
The 2009 Physical Health Care of Mental Health Clients Initiative, launched by Minister Perry stated that:

“All NSW mental health services have a responsibility to ensure that the people who use their service receive adequate physical health care. A physical health examination will help the mental health service make sure the client receives the right care and treatment for their illness – whether its cause is of a physical or a mental nature, or both.”

Aim
The aim of the project is that at the end of a six-month period, at least 60 per cent of mental health clients in the project sample will have seen a GP or other health care provider for physical health issues.

Problem identified
There is an identified need to work collaboratively with other health care professionals, particularly GPs, to improve the physical health of people who use a mental health service.

Utilising the computer database for the project sample group of clients to analyse available data, the statistics revealed that:

20% of mental health clients in the Blacktown/Mt Druitt Local Government Area are well linked in with their GP and report that all physical health needs are being met:

• 35% of mental health clients have a GP, but have had no contact with them in the last 12 months
• 45% of mental health clients have no GP
• 39% of mental health clients have diabetes
• 65% of mental health clients are obese
• 81% of mental health clients smoke
• 87% of mental health clients have high caffeine intake (through coffee, cola, energy drinks etc).

Changes made
One hundred and eighty five clients who attended the clozapine clinic were asked if they would like to participate in the project. All consented to be involved. Each mental health client was surveyed individually. Using a simple tick box questionnaire, clients were asked about:

• their GP details
• their smoking history
• diabetes
• high blood pressure
• any obesity issues including diet and exercise
• their caffeine intake.

Bloods (BSL and cholesterol level) were also obtained with consent.

A basic physical health assessment was performed for each client. This included measurement of height, weight, blood pressure, temperature and conduct of investigative blood tests, including full blood count and random glucose and lipids.

The clients who had no GP or had no GP contact for longer than 12 months, were provided with a list of GPs in the vicinity of their home. The client had one month to choose a GP and provide details.

A letter was sent to each GP, with a copy of the individual client’s investigative blood results, requesting a comprehensive physical health assessment including (as appropriate) breast checks, pap smears and prostate examinations. The GP was asked to contact the Sydney West Area Health Service when the client presented, in order to facilitate future collaborative management.

Each client’s GP details were entered into the computer database.
"You begin with the end in mind, by knowing what you dream about accomplishing and then figure out how to make it happen”

Jim Pitts
Northrop Grunman Corporation

Measurement/process measures

Of the project group of clients, to date:

- 20% of mental health clients have a regular GP and have attended for a physical health assessment
- 33% of mental health clients have re-established contact with their GP and 19 per cent have had a physical health assessment
- 31% of mental health clients have chosen a GP and 18 per cent have had a physical health assessment
- 16% of mental health clients who are mentally stable are unwilling to pursue physical health needs at this time.

The project has also achieved the establishment of linkages with Blacktown and Mt Druitt General Practice Association, and with Health One, Mt Druitt and has built on existing linkages with Went West (formerly the Division of General Practice).

Over 80 per cent of mental health clients complied with the request to visit their GP. Most clients have had mental health care plans written by the GP which have enabled them to seek further investigative procedures. Mental health care plans have also allowed some clients to have dental work carried out. Referrals to psychologists for ongoing counselling were also given.

Plans to sustain change

Department of Health has rolled out a simple education package via the internet for all clinical providers. Staff education will be provided for the use of this education package.

While this initiative has initially been undertaken with a manageable sample of clients, it will be rolled out to the various teams within the service, with education in-services to staff.

More communication exchange with GPs and other health professionals is required to maintain collaborative care plans for all clients.

It is also planned to incorporate physical health assessment into client clinic attendance, and to equip mental health workers with information on clients’ overall health and wellbeing.

A regular review of processes to ensure their sustainability and effectiveness is also planned.
Decreasing echo reporting time for out-patients

Dr Megan Sherwood
Staff Specialist
Sydney Children’s Hospitals Network, Westmead

Problem/Background
Echocardiogram (cardiac ultrasound) reports were not always available in short time for access by clinicians other than cardiologists. This, in turn, meant that billing could not be submitted to Medicare, as the report is a requirement prior to payment.

A solution to this problem was sought by clinicians and administrative staff. Phone calls requesting reports were received regularly from other departments, particularly for oncology outpatient echo reports. Additional time was required by administrative staff to confirm whether billing could be submitted. This took staff away from clinically-related activities.

Aim
The aim of the project was to have 100 per cent of echocardiogram reports for outpatients written within two weeks of the echocardiograms (cardiac ultrasound study). The project aimed to achieve this within six months.

Problem identified
The process of an echo being performed and reviewed and reported is seen in Figure 1.

Echocardiograms may be performed by a cardiologist, cardiology fellow, or cardiac sonographer. All final reports are written and signed by a cardiologist.

The potential causes for delay in completing echo reports included clinical and information technology components (see Figure 2). It is frequently not possible for the reports to be written, either as a provisional or final report during the clinical encounter, as time constraints and patient throughput considerations often intervene. Other urgent clinical commitments can delay the process. In the last two years a new digital imaging system has been installed, which has taken time for staff to learn. Additionally, reporting requires two IT systems to be utilised simultaneously, both the digital imaging and the DOS-based reporting programs. Therefore, reporting can only be performed within the hospital. Lastly, other clinicians access the reports electronically via Powerchart. The transfer of reports to Powerchart does not always occur and thus other teams in the hospital cannot view the reports.

A solution that did not increase workload significantly was sought. A list of unreported and thus unbillable studies could be readily obtained from the IT billing system and sent to individual cardiologists, to alert them to echo reports that were not complete. More complex interventions involving IT systems and upgrading of systems would have solved other aspects of the problem, but would have required significant financial outlay.

Figure 1. Flow chart of the workflow of echo reporting
Changes made
A list of unreported outpatient echocardiograms was provided individually to each cardiologist monthly. The list was generated by one member of the administrative staff as part of the monthly billing process, and the number of reports outstanding for two weeks or more was determined. This served as a reminder list of reports that were still required. The cardiologist could report the echocardiograms at a time that was convenient to each individual.

Measurement/process measures
Historical data regarding echocardiogram reporting was obtained from the previous year (2010). The number of outpatient echocardiograms unreported after two weeks (see Figure 3) and the total number of outpatient echocardiograms performed were charted (see Figure 4). A delay between collecting the historical data and the data related to implementation occurred, as reflected by the gap in the graph. Only early data is available, however, the number of reports over two weeks is now below the lower control limit, while the number of echocardiograms performed remains between the upper and lower control limits. This suggests there may have been a positive effect from the implementation. More data will be required for clarification.

Plans to sustain or spread change
At present, it is planned to continue collecting data to the six-month stage as detailed in the aim. Further assessment will be required at that time.

Figure 2. Cause and effect diagram

Figure 3. Outpatient echocardiograms unreported after two weeks
Number of studies unreported more than two weeks after study

Figure 4. Total number of outpatient echocardiograms performed.
Number of outpatient echocardiograms
Improving Accuracy of Admitted Medical Patients’ Medications Charted in the Emergency Department

Susan Murtagh
Director of Pharmacy Belmont Hospital, Hunter New England Local Health District

Problem/Background
In the health care setting, risks to patient safety may arise when there is incomplete communication between personnel during times of care transition. Patients are often at risk of care fragmentation during an episode of illness, and the elderly, particularly, are the group with the highest errors and adverse events associated with transfer between care settings. These include transition between hospitals, between wards within hospitals and from hospital to home and/or to or between residential aged care facilities. Assuring medication accuracy at transitions of care through medication reconciliation is one of the evidence-based solutions to reduce medication risks.

Aim
Within four months to increase the accuracy of medications charted by 20 per cent for medical patients admitted to Belmont Hospital (BH) via the Emergency Department (ED).

Problem identified
It was identified from a retrospective audit from the ED, of the medication charts of medical patients admitted to Belmont Hospital that 100 per cent of patients had at least one medication chart error, including omissions of medications or incomplete drug orders.

The average age of patients in the audit was 82 years, and an average of 12 medications was charted per patient.

Changes made
An ED clinical pharmacy service was introduced for medical patients to be admitted to BH, to reconcile the medications, prior to the medical registrar charting them. This was a 20-hour per week service on weekdays.

Measurement/process measures
- In a four monthly follow-up audit of medical patients’ medication charts, half had their medications reconciled by a pharmacist in ED.
- The average age of patient at the second audit was 78 years, with an average of 10 medications charted per patient.
- 63 per cent of patients either had their medications reconciled by a pharmacist, or had no medication errors.
- The 37 per cent of medical patients who had a medication error did not have their medications reconciled in ED by a pharmacist. Errors included drugs omitted (e.g., esomeprazole), wrong drug charted (Mixtard® 30/70 instead of Novomix® 30), or incorrect strength (carvediol 25mg charted instead of 6.25mg, resulting in a SAC2 incident).
- There was a 63 per cent improvement in the accuracy of medication charting and medication information available for the medical registrar when prescribing medications in ED for medical patients.
- In addition there was the benefit of having a pharmacist available in the ED for medication enquiries and counselling of patients about their medications.

Plans to sustain or spread change
To ensure the processes are maintained and that the improvements will be sustained:
- an ED Pharmacy Service 0.5 FTE pharmacist has been funded (through Caring Together funding)
- results have been presented to the BH Drug Advisory Committee
- the pharmacist has become an integral part of ED’s clinical team and now attends morning clinical handover
- a re-audit is scheduled to occur in six months, to ensure that the results are sustained and that there is continued improvement
- An enhancement proposal is to be prepared to increase the ED clinical pharmacist position to 1.0 FTE.
Improving Patient Care and Outcomes within the Medical Assessment Unit (MAU) and Medical Assessment Unit Emergency Department (MAUED)

Terena McIntosh
Nursing Unit Manager
Medical Assessment Unit
Royal North Shore Hospital
Northern Sydney Local Health District

Problem/Background
The first medical assessment unit (MAU) model of service delivery was introduced to RNSH in 2008 and was commissioned on the 12th floor of the hospital, with 21 beds. This unit was previously a 17-bed rehabilitation transition unit.

Due to a number of reasons, the MAU was not operating at its full potential. These included:
- A mismatch between the staff’s clinical expertise and that required for the new patient population in the MAU
- Availability of clinical education for staff prior to the MAU opening
- High attrition rate of clinical leaders
- Under-utilisation of the MAU, due to its location in relation to the Emergency Department (major source of referrals)

With the unit unable to operate at its full potential, due to the described reasons above, the MAU was not able to achieve the NSW Health key performance indicators (KPIs) which were:
- Number patients admitted
- Total hours in ED
- Total hours in MAU
- Discharge/transfer of patients within 48 hours
- Overall length of stay (LOS)
- Patient re-admission rate.

Aim
To ensure that the Medical Assessment Unit (MAU) at RNSH is a unit which delivers safe, quality patient care and meets the key performance indicators set by NSW Health by August 2010.

Changes made
1. A team values and mission statement developed
   - Staff were actively engaged to participate in the development of values for the ward, with the intention to provide an environment where they felt empowered to have ownership of their workplace and all work towards a common goal.
   - Business rules were developed from this exercise.

2. Development of a professional portfolio
   - A MAU focus group was developed and formed by the nursing staff of MAU. This involved workshops looking at the skills required to be a competent MAU nurse.
   - A professional portfolio was developed for nursing staff.

3. Admission and discharge criteria
   - Triage category 3 and 4 patients were identified for MAU at triage.
   - New MAUED admission criteria created, including exclusion criteria.
• Specialist access nurses were trained by the CNC to identify appropriate patients for MAU after hours.
• Agreement with the patient flow manager that a minimum of two patients will be discharged from MAU daily.

4. Recruitment drive
• The clinical nurse consultant and clinical nurse educator (24 hours) were employed.
• An internal expression of interest for secondments into the unit was sent out to hospital staff, resulting in the employment of 1 FTE.
• NSW Health recruitment drive successfully employed 4 FTE with critical care experience.

5. Increasing the awareness and understanding of MAU model of care
• Including an aged care referral, blanket provision of allied health services to outlier patients. Communication of the NSW MAU KPIs to staff.
• Continual communication with patient flow managers, after hours managers and nursing staff within unit.
• Improving the communication with the Emergency Department via in-services and the continual development of relationships between clinicians in both units.

Measurement/process measures
• Staff are demonstrating the values developed in April 2010.
• Recruitment of 8 FTE has assisted staff morale and knowledge and skill mix within scope of practice.
• Retention of three transitional registered nurses from 2010 intake.
• The development of professional portfolios has given staff direction to develop essential MAU clinical skills.
• In August 2010, the monthly KPIs were improved, as below in Table 1.

In November 2010, the MAU has continued to meet all four KPIs set by NSW Department of Health. This demonstrates that patient care and outcomes have improved considerably and system changes have been sustained.

Plans to sustain or spread change
• To ensure that there is ongoing communication with key stakeholders will continue – particularly patient flow managers and ED.
• To use the professional portfolios developed during staff’s performance appraisal interviews.
• Communication of the organisational and unit’s vision and values, evaluation that these values are evident in clinical practice and ensure that this process is reviewed as needed i.e., 18-months time.
• The MAU team will participate in the Essentials of Care program in 2011. Facilitators have been trained and preliminary meetings have taken place.
• There will be further recruitment for identified nursing vacancies as needed and the clinical nurse education hours will be increased to 32 hours per week.

Table 1. Improvement in all KPIs

<table>
<thead>
<tr>
<th>KPI</th>
<th>Pre-project</th>
<th>August 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Throughput goal 150 patients</td>
<td>75</td>
<td>160</td>
</tr>
<tr>
<td>Time in ED goal &lt; 6hrs</td>
<td>9.0</td>
<td>4.3</td>
</tr>
<tr>
<td>Readmits goal &lt; 10%</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>Average Length of Stay in MAU goal &lt;48hrs</td>
<td>49</td>
<td>35</td>
</tr>
<tr>
<td>Average Length of Stay after transfer from MAU goal 7 days</td>
<td>7.5</td>
<td>7.0</td>
</tr>
</tbody>
</table>
Clinical Leadership Program

PiVITAL Partnerships – Patient/Carer/ Clinician

Meegan Connors
Clinical Lead Surgical Services
Re-design, Orange Health Service
Western NSW Local Health District

Problem/Background
The Incident Information Management System (IIMS), clinical management, complaints data and observation of practice, provided evidence of poor, to incongruent, information being shared with the patient and/or families and between teams in relation to clinical planning of the care journey.

A review of communication and information transfer, between and within teams, identified a lack of cohesion and collaboration between care providers, resulting in service inefficiency and loss of information during handover.

Clinical handover, between teams and shifts, was identified as the key process that required redesigning in the service area and beyond, to reduce the loss of information in transfer, whilst also providing a platform for the patient and all team members to remain informed.

Aim
The aim of the project was to develop and implement a multidisciplinary approach to clinical handover, that values the patient/carer and broader clinical team as contributors in the transmission and sharing of information and ideas, directly associated with the patient care journey.

Problem identified
A number of themes were identified through direct observation and data analysis. First, communication between clinicians and patients/carers was not consistent throughout the patient journey. Second, handover and communication between teams was ill-timed and at times inconsistent. Third, information was lost in transfer between teams and between shifts. Fourth, handover rounds were ad hoc, often with multiple medical teams in attendance at the same time.

Observation of clinical handover practices and interaction between teams was undertaken within the surgical inpatient units. Key issues identified were:

1. Clinical handover did not start on time; was inconsistent; information was lost in transfer; documentation was not complete or consistent.
2. Handover lacked leadership and participation of all key stakeholders.
3. Patients were often not invited into, or engaged in, the handover discussion.
4. Some personal information shared by clinicians at the bedside in shared accommodation was sensitive or inappropriate.
5. Handover tools did not provide consistent guidance for information delivery.
6. Clinical handovers occurred at different times, making it difficult for all clinicians to be involved.
7. Ad hoc clinical handover resulted in “silos” decision-making, rather than collaborative approaches to care.
8. Not all clinical disciplines were present to support decision-making and care planning.
9. Clinician to clinician handover did not occur between referring/transferring inpatient units.
10. Information gathered in handover was not prioritised or delegated appropriately.

A retrospective review of clinical management and complaint incident data identified and supported the observation that communication was a key issue affecting the patient/carer health journey.

Key stakeholders were consulted and asked what they felt would improve the current processes of communication.

Changes made
A procedural guideline was developed in consultation with patients/carers and clinical staff for the provision of bedside handover, following analysis of issues highlighted in staff and
patient interviews. The guideline was introduced to clinical staff, with supportive education and role-playing to promote acceptable practice. In consultation with nursing staff a standard handover template was designed and developed, to guide information delivery and gathering at the bedside. A “Ward Round” book was developed to support team communication between teams.

Clinical staff were mentored by clinical educators and the NUM, to engage the patient in handover – supporting the need for leadership and responsibility for information gathering and sharing.

Surgeons were approached by the NUM to propose the introduction of combined medical/nursing inpatient unit “round”. The introduction of an acute surgical team provided further support to the handover process.

Team leader roles were allocated, who, in turn, assumed responsibility with the NUM to attend medical rounds each morning. The team leader/NUM maintained a record of patient care requirements in a dedicated ward round book.

Clinicians were encouraged and supported by the project team in the initial phase and as required during the project period.

**Measurement/process measures**

Clinical handover engaged 100 per cent of patients/carers, with each member of the team being valued as an important contributor to the information shared. The surgical unit has seen a 5 per cent improvement in handover processes, which has had a flow-on effect to the completion of clinical documentation.

Clinical documentation improved in bedside records, in direct relation to clinical handover and introduction of a new documentation tool set following the CSEP (Clinical Standards Evaluation Program) audit in November 2010.

Medical rounds commenced after the nursing shift-to-shift handover and treating teams staggered their arrival in order to have the team leader/NUM available to support decision-making for patient care during integrated clinical handover rounds.

Escalation of clinical concern occurred immediately, if the patient was clinically compromised.

Patient treatment needs were actioned in a timely manner, facilitating greater patient satisfaction and service efficiency.

Clinical handover was provided to receiving facilities when patients were transferred to neighbouring and or tertiary services (when destination was confirmed), which is important for patient safety and established clinical networks.

The project has significantly enhanced the relationships between professional groups and patients/carers, resulting in a more consultative and collaborative approach to communication, care planning and decision-making.

Patients reflected a 31.28 per cent improvement in the General Inpatient Satisfaction Survey, for being included in planning their care journey. Additionally, patients reported that they felt they received the correct amount of information about their care, resulting in a 16 per cent improvement. Overall, patient satisfaction improved in all areas associated with communication and inclusion in decision-making throughout the care journey.

Both patient and staff satisfaction has been evident as the project evolved, through the creation of better experiences for people using and working within our health service.

**Plans to sustain or spread change**

The project is currently undergoing evaluation and enhancement, with the merger of two surgical units at the new health service. The project will be presented to the staff and implemented with the support of the clinical educator and clinical nurse specialists as key leaders. The procedural guidelines and handover tools will be submitted to the facility executive for implementation across all facility service areas.

It is envisaged that the project will influence the establishment of a verbal clinical handover from neighbouring facilities, when transferring patients into the health service and from the health service to facilities receiving patients for ongoing care.

With the establishment of the emergency surgical service, the handover project has enhanced clinical relationships and the importance of collaborative clinical communication in optimising patient satisfaction and flow, reducing duplication of services and improving patient safety.
Improving Emergency Department (ED) Processing Time

Dr David Mah
Director of Emergency Medicine Training, South Eastern Sydney Local Health District

Problem/Background
Overcrowding in the Emergency Department (ED) has been identified as an issue at Sutherland Hospital, due to delays in the availability of inpatient beds and prolonged ED processing time. ED processing time is the time interval between the time the patient was first seen by a health professional and the departure ready time from ED. The ED staff have minimal influence on the availability of inpatient beds but could influence the processing time in ED for patients who are to be admitted.

Aim
Within six months reduce the number of admitted patients with ED processing time > 8 hours by 50 per cent.

Problem identified
The project team met and brainstormed the causes of prolonged ED processing time. See Figures 1 and 2.

Changes made
The team discussed ED access block in our weekly departmental meeting and implemented various strategies over six months to improve ED processing time. Multiple interventions were attempted including:

- Having a patient quota for ED junior medical officers
- Abolishing radiology registrar approval for requesting CT scans or ultrasounds
- Mandatory surgical admission for radiology investigations
- One way referral for inpatient team
- One-hour inpatient admission rule was implemented

Measurement/process measures
Run chart showing ED Processing Time June – Dec 2010. See Figure 3.

Plans to sustain or spread change
The more permanent senior ED nursing staff have been encouraged to enforce the implementation of the various ED strategies. As for the more transient (every 10-12 weeks) junior medical staff, educating them and empowering them to implement the ED strategies are a constant challenge.

Figure 1. Cause and Effect Diagram
Figure 2. Causes of Prolonged ED Processing Time

Causes of Prolonged ED Processing Time

Figure 3: ED Processing Time > 8 hours

Implemented admission rule
Listing of Clinical Leadership Program Projects 2010/2011

Ambulance Service of NSW

**Executive Modular CLP – May 2010 intake**

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting to the correct address the first time</td>
<td>Sean Kearns</td>
<td>Zone Manager Sydney North Sector</td>
</tr>
</tbody>
</table>

**Foundational Statewide CLP**

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Turnaround Times for Genetic Tests</td>
<td>Bruce Bennetts</td>
<td>Department Head</td>
</tr>
<tr>
<td>Improving Continuity of Care in the Orthotic Department Through Improving Documentation</td>
<td>Vicky Cavanagh</td>
<td>Senior Orthotist - Deputy Head</td>
</tr>
<tr>
<td>Time out in Radiology</td>
<td>Robyn Crapp</td>
<td>NUM Medical Imaging</td>
</tr>
<tr>
<td>Access to Psychological Medicine Documentation</td>
<td>Anne Duffy</td>
<td>Administration Manager</td>
</tr>
<tr>
<td>Nutrition in Cystic Fibrosis Patients</td>
<td>Christie Graham</td>
<td>Senior Dietitian, CF team</td>
</tr>
<tr>
<td>Clinical handover from day shift physiotherapists to the evening physiotherapist</td>
<td>Natasha Hankin</td>
<td>Senior Physiotherapist</td>
</tr>
<tr>
<td>E-documentation Diabetes Service</td>
<td>Kristine Heels</td>
<td>Nurse Manager of Diabetes</td>
</tr>
<tr>
<td>Negotiated Care</td>
<td>Karen Rankin</td>
<td>Clinical Nurse Consultant, Feeding IBD</td>
</tr>
<tr>
<td>Improving Clinical Handover</td>
<td>Susan Sampson</td>
<td>CNC Adolescent Medicine</td>
</tr>
<tr>
<td>Minimising intravenous extravasations</td>
<td>Duc Van, Loren Hay</td>
<td>Staff specialist ED, CNS</td>
</tr>
<tr>
<td>Improving Documentation in Allied Health</td>
<td>Prue Wales</td>
<td>Social work and Team Leader</td>
</tr>
<tr>
<td>Access to Emergency OT</td>
<td>Heidi Webber</td>
<td>Nurse Manager, Operating Suite</td>
</tr>
<tr>
<td>Improving the Efficiency of Outpatient Letters Back to Referring Doctors</td>
<td>Kathryn Weir</td>
<td>Nurse Manager</td>
</tr>
</tbody>
</table>

**Executive Modular CLP – May 2010 Intake**

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<tr>
<th>Project Title</th>
<th>Name</th>
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<tbody>
<tr>
<td>Minimising Adverse Mental Health Effects of HCV Treatment in Children and Adolescents</td>
<td>Karen Munro</td>
<td>Senior Clinical Psychologist, Head of Psychology</td>
</tr>
<tr>
<td>Decreasing the Lag Time for Echo Reports for Out-Patients</td>
<td>Megan Sherwood</td>
<td>Staff Specialist</td>
</tr>
</tbody>
</table>

*Note: the listing of projects is by Area Health Service in 2010. NSW Health moved to Local Health Networks/Districts in 2011.*
# Greater Southern Area Health Service

## Foundational Statewide CLP

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQuiP Accreditation / Phase 3 in Eastern Sector</td>
<td>Elaine Almond</td>
<td>Manager, Clinical Risk Management</td>
</tr>
<tr>
<td>Focussing on Mental Health Partnerships</td>
<td>Alison Bradley</td>
<td>Project Manager, Clinical Redesign Mental Health</td>
</tr>
<tr>
<td>Wellbeing of Mental Health &amp; Drug &amp; Alcohol Clients</td>
<td>Lorraine Connell</td>
<td>Mental Health Clinician, Community Mental Health</td>
</tr>
<tr>
<td>Memory Morning Tea – an Innovative Support Initiative</td>
<td>Peter Davis</td>
<td>Clinical Nurse Consultant, Dementia</td>
</tr>
<tr>
<td>Transfers of People with Mental Health Problems between Health Facilities: Optimisation of the Memorandum of Understanding</td>
<td>Sue Dentice</td>
<td>Clinical Nurse Consultant, Mental Health Emergency Department</td>
</tr>
<tr>
<td>Keep them Moving</td>
<td>Emily Farquhar</td>
<td>Physiotherapist in Charge, Physiotherapy Dept.</td>
</tr>
<tr>
<td>Let’s get Talking</td>
<td>Denise Hogan</td>
<td>Clinical Nurse Consultant, Psychogeriatric Unit</td>
</tr>
<tr>
<td>Management of Metabolic Syndrome Screening in Mental Health Consumers</td>
<td>Pauline Kelly</td>
<td>Team Manager, Community Mental Health</td>
</tr>
<tr>
<td>Malnutrition Screening</td>
<td>Peta Larsen</td>
<td>A/Senior Dietitian, Dietetic Services</td>
</tr>
<tr>
<td>No Waiting – Are You Being Served</td>
<td>Marie Loudon</td>
<td>Nurse Manager, Operating Theatre</td>
</tr>
<tr>
<td>Management of Medications in Bedside Lockers</td>
<td>Narelle McKenzie</td>
<td>Nurse Unit Manager, Maternity Unit</td>
</tr>
<tr>
<td>Implementation of an Education Component including Action Plans into an existing Pulmonary Rehabilitation Program</td>
<td>Cherie Mercado</td>
<td>Senior Physiotherapist, Community Health</td>
</tr>
<tr>
<td>Continuum of Care: Using Mental Health Outcome Assessment Tools (MHOAT) Care Plans and Outcome Measures to Improve the Care Planning Process for SMHSOP</td>
<td>Anka Radmanovich</td>
<td>Clinical Leader, Mental Health</td>
</tr>
<tr>
<td>Clinical Process Review</td>
<td>Cheryl Rogers</td>
<td>Clinical Nurse Consultant, Specialist Mental Health</td>
</tr>
<tr>
<td>Improving Hand Hygiene in the Critical Care Unit at Griffith Base Hospital</td>
<td>Skye Vagg</td>
<td>Team Leader/Clinical Nurse, Educator Intensive Care</td>
</tr>
<tr>
<td>Medication Safety Improvement for the Eurobodalla</td>
<td>Lisa Wilson</td>
<td>Nurse Manager</td>
</tr>
<tr>
<td>Evaluation of Cardiac Rehabilitation Program in Bega Valley</td>
<td>Maria Wilson</td>
<td>A/Community Health Nurse Manager</td>
</tr>
</tbody>
</table>
### Executive Modular CLP – May 2010 Intake

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Surgery Unit Pain Management</td>
<td>Andrew Dagg</td>
<td>Nurse Manager, Health Service</td>
</tr>
<tr>
<td>Reducing the Length of Stay in a Sub-Acute Unit for Patients who are Awaiting Long Term Residential Aged Care</td>
<td>John Gale</td>
<td>Senior Nurse Manager</td>
</tr>
<tr>
<td>Griffith Base Hospital Doctors Hand Hygiene Project</td>
<td>Damien Limberger</td>
<td>Executive Medical Director</td>
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### Greater Western Area Health Service

#### Foundational Statewide CLP

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<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whose Care Plan Is It?</td>
<td>Jenelle Crowe</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Sub-Acute Care Team - The Implementation of the Orthogeriatric Model of Care within the Orange Health Service</td>
<td>Tracey Drabsch</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Nurse Practitioner role in ED</td>
<td>Kate Hain</td>
<td>Nurse Practitioner, Emergency Department</td>
</tr>
<tr>
<td>Community MRSA - Yours, Mine, Ours</td>
<td>Kim Hansen, Suzanne Lovell-Smart</td>
<td>NUM, Community Nursing/ CAPAC/ Ambulatory Care, Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>Bloomfield Rehabilitation Corridors Initiative – Moving Away from the Silo Approach</td>
<td>Bruce Hogben</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Referral Process for Inpatient Rehabilitation Units</td>
<td>Robyn Jeffrey</td>
<td>Clinical Leader, Rehabilitation &amp; Partnerships</td>
</tr>
<tr>
<td>Improving access to IVF Services for Rural and Remote Women</td>
<td>Leonie Parker</td>
<td>Nurse Practitioner, Women’s Health</td>
</tr>
<tr>
<td>Dubbo Women’s Health Aboriginal Referral and Access program</td>
<td>Joanne Phillips</td>
<td>Clinical Nurse Consultant, Women’s Health</td>
</tr>
</tbody>
</table>

### Executive Modular CLP – May 2010 Intake

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>PiVITAL Partnerships – Patient/Carer/Clinician A multidisciplinary approach to clinical handover</td>
<td>Meegan Connors</td>
<td>Clinical Lead Surgical Service – Redesign</td>
</tr>
<tr>
<td>Miles to Travel – Rural Pregnancy Care</td>
<td>Sharon McKay</td>
<td>Acting General Manager of Rural Clinical Service, Operations Manager</td>
</tr>
<tr>
<td>Improving Orthopaedic Patient Flow in Fracture Clinics</td>
<td>Ben Milne</td>
<td>Head of Orthopaedic Department</td>
</tr>
</tbody>
</table>
## Hunter New England Area Health Service

### Foundational Statewide CLP

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<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Reducing Time Spent in the Waiting Rooms at the Ante-Natal Diabetic Outpatients Clinic</td>
<td>Sham Acharya</td>
<td>Consultant Endocrinologist, John Hunter Hospital</td>
</tr>
<tr>
<td>Reducing Paediatric Emergency Length of Stay</td>
<td>Michael Anscombe</td>
<td>Staff Specialist, Emergency Dept John Hunter Hospital</td>
</tr>
<tr>
<td>Discharge Letter Compliance Study Lower Hunter Community Health Home Nursing Service</td>
<td>Maree Auer</td>
<td>Nurse Unit Manager, Lower Hunter Community Health</td>
</tr>
<tr>
<td>Intravenous Cannula Care Plans</td>
<td>Susan Coleman</td>
<td>Nurse Unit Manager, Emergency Dept, Moree</td>
</tr>
<tr>
<td>Moree Oncology – Closer to Home</td>
<td>Bronwyn Cosh</td>
<td>Clinical Nurse Manager, Moree</td>
</tr>
<tr>
<td>Improve access to health care for homeless young people in crisis accommodation</td>
<td>Tracey Finn</td>
<td>Clinical Nurse Consultant/Team Leader Youth Health; Kaleidoscope, JHCH</td>
</tr>
<tr>
<td>Nothing Left Behind</td>
<td>Alison Fullbrook</td>
<td>Nurse Unit Manager, Operating Suite John Hunter Hospital</td>
</tr>
<tr>
<td>PTA Testing in the Community by the CAPAC HITH Service</td>
<td>Jacqueline Greenham</td>
<td>Service Development Co-ordinator, CAPAC Service, Greater Newcastle Sector</td>
</tr>
<tr>
<td>The Development and Implementation of a new Discharge Package</td>
<td>Kristin Haynes</td>
<td>Nurse Unit Manager, Mental Health Unit Newcastle</td>
</tr>
<tr>
<td>Midwife-led counselling model “Birth story” for the postpartum woman</td>
<td>Lynette Kramer</td>
<td>Midwifery Unit Manager John Hunter Hospital</td>
</tr>
<tr>
<td>Examining the Client Journey from Intake to Service Provision</td>
<td>Belinda Latimore</td>
<td>Snr. Social Worker Cessnock/Kurr Health Service</td>
</tr>
<tr>
<td>To improve Newcastle/Lake Macquarie Advisory Service Discharge Letter Compliance</td>
<td>June Morris</td>
<td>Service Manager, Social Worker, Dementia Service, Greater Newcastle Sector</td>
</tr>
<tr>
<td>S.A.N.D Project - A Method for Observing, Describing and Documenting Hallucinations in an Older Peoples’ Mental Health Inpatient Unit</td>
<td>Petra Muir</td>
<td>Staff Specialist, Psychogeriatrician</td>
</tr>
<tr>
<td>Mater Mental Health - Improving the accuracy of Medications Charted for Medical Patients admitted to Belmont Hospital via ED</td>
<td>Susan Murtagh</td>
<td>Director, Pharmacy, Belmont Hospital</td>
</tr>
<tr>
<td>Allied Health Screening Tool</td>
<td>Leigh Philpott</td>
<td>Clinical Social Work Consultant, Mental Health, Peel Cluster</td>
</tr>
<tr>
<td>Excellence! How do we sustain it?</td>
<td>Elizabeth Smith</td>
<td>Nurse Manager, Emergency Dept, Maitland Hospital</td>
</tr>
<tr>
<td>The Implementation of Skin Integrity Documentation in the Peri-operative Phase, for Patients with a Fractured Neck of Femur as a Result of Trauma</td>
<td>Anthea Swann</td>
<td>Clinical Co-ordinator, Operating Rooms, Armidale Hospital</td>
</tr>
<tr>
<td>Defining Reasonable Workloads for Lower Hunter Occupational Therapists</td>
<td>Angela Towns</td>
<td>Snr Occupational Therapist, Cessnock Health Service</td>
</tr>
<tr>
<td>Improving Breastfeeding Rates in the Narrabri Catchment Area</td>
<td>Kate Winston-Smith</td>
<td>Clinical Nurse Manager, Narrabri</td>
</tr>
</tbody>
</table>
Executive Modular CLP – May 2010 Intake

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<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>To recognise Acute Radiation Enteritis Early and Prevent Hospital Admission</td>
<td>Anne Capp</td>
<td>Director for Radiation Oncology</td>
</tr>
<tr>
<td>Challenges in Effective Implementation of the Paediatric ‘Between the Flags’ education program</td>
<td>Leanne Crittenden</td>
<td>Co-ordinator, Northern Child Health Network</td>
</tr>
<tr>
<td>Reducing Patient Risk and Improving Flow in a Stand-Alone Endoscopy Unit</td>
<td>Patrick Farrell</td>
<td>Director Anaesthesia, GNS</td>
</tr>
<tr>
<td>Collaborative Care Plan Documentation Completion</td>
<td>Margarett Terry</td>
<td>Service Director Mental Health &amp; Substance Use Service</td>
</tr>
</tbody>
</table>

Justice Health

Foundational Statewide CLP

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring about the Carers</td>
<td>Catherine Hancock</td>
<td>Nurse Manager, Community Correctional Mental Health</td>
</tr>
<tr>
<td></td>
<td>Katrina Meggison</td>
<td>Clinical Nurse Consultant, Mental Health</td>
</tr>
<tr>
<td>PAS Triaging Guideline Project 2010</td>
<td>Katja Kreft</td>
<td>Nursing Unit Manager (MMTC)</td>
</tr>
<tr>
<td></td>
<td>Abraham Mahachi</td>
<td>Nursing Unit Manager (Emu Plains)</td>
</tr>
<tr>
<td>Engage, Inform, Plan, Act in the Forensic Hospital</td>
<td>Karen Lawes</td>
<td>Nurse Unit Manager, Acute Mental Health, Forensic Hospital</td>
</tr>
<tr>
<td></td>
<td>Elizabeth Roberts</td>
<td>Clinical Nurse Consultant, Acute Mental Health, Forensic Hospital</td>
</tr>
<tr>
<td></td>
<td>Nicole Theuer</td>
<td>Nurse Manager, Forensic Hospital</td>
</tr>
<tr>
<td></td>
<td>Terri Vaughan</td>
<td>Nurse Unit Manager, Long-stay Unit Forensic Hospital</td>
</tr>
<tr>
<td>Ease the Wheeze</td>
<td>Suzanne Riach</td>
<td>Clinical Nurse Consultant (Adolescent)</td>
</tr>
</tbody>
</table>

Executive Modular CLP – May 2010 Intake

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<tbody>
<tr>
<td>Establishment of Consultation – Liaison Psychiatric Service, Long Bay Hospital</td>
<td>Gerald Chew</td>
<td>Deputy Clinical Director, Inpatient Mental Health</td>
</tr>
<tr>
<td>The Equipment Project - Ensuring Access to Medical Equipment by Clinicians in Justice Health</td>
<td>Stephen Hampton</td>
<td>Acting Clinical Director, Primary and Women’s Health</td>
</tr>
<tr>
<td>Developing a Clozapine Service in Custodial Setting</td>
<td>Adam Martin</td>
<td>Acting Clinical Director, Ambulatory Mental Health</td>
</tr>
<tr>
<td>DAWN - Drug and Alcohol Withdrawal Now - Improving Management of Pregnant Incarcerated Women.</td>
<td>Jillian Roberts</td>
<td>A/Clinical Director, Drug and Alcohol</td>
</tr>
</tbody>
</table>
North Coast Area Health Service

Foundational Statewide CLP

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Hands on Deck – all Simple Surgical Repairs of Flexor Tendon Injuries of the Hand, will have a Physio Appointment Arranged on Discharge</td>
<td>Elizabeth Armstrong</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Go with the Flow – The Clock is Ticking: Improve Patient Care in Grafton ED through Introduction of a Clinical Initiatives Nurse</td>
<td>Raelene Austin</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>A happy Therapist is a Productive Therapist – implement professional conduct for the Occupational Therapists</td>
<td>Dan Bock</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Who’s Who – Improve Participation and Access for Aboriginal People with Cardiac Conditions into the Cardiac Rehabilitation Program</td>
<td>Marilyn Body</td>
<td>Clinical Nurse Consultant</td>
</tr>
<tr>
<td>Unlocking the Door – Redressing the Balance</td>
<td>Martin Gallagher</td>
<td>Nurse Unit Manager, Mental Health IPU</td>
</tr>
<tr>
<td>Bowel Management Chart – to Improve the Patient’s Length of Stay and Outcomes Through Bowel Management</td>
<td>Janet Heapy</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Bugs in Blood – Decrease the Number of Blood Cultures Collected on Patients in ED</td>
<td>Wendy Jackson</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Paediatric Triage EMR</td>
<td>Lisa Jarvis</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Going Home – the Patient Journey Continues</td>
<td>Linda Kay</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Did You Know? To Improve and Promote Healthy Living in the Community</td>
<td>Kerry Keyte</td>
<td>Administration Officer</td>
</tr>
<tr>
<td>Life Saving Online – an Online Learning and Assessment Tool for Advanced Life Support</td>
<td>Dennice Lockhart</td>
<td>Area Nurse Educator</td>
</tr>
<tr>
<td>No Gain from Pain – Introduction and use of the Universal Pain Assessment Tool</td>
<td>Cath Osbourne</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>What to Know Before You Go – an ED discharge Information sheet for simple injuries</td>
<td>Kassandra Packwood</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Successfully Develop and Implement a Process to Monitor Patients after Zyprexa Relprev Injections</td>
<td>Anne Pudney</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>A Happy Workplace – Improve Quality of Patient Care by Improving Workplace Morale and Relationships</td>
<td>Anne Smithers</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Improve Discharge Management of Intermediate Risk Acute Coronary Syndrome Patients discharged from ED Whilst Waiting for a Stress Test</td>
<td>David Tess</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Improving Participation and Access for Aboriginal Patients into Cardiac Rehabilitation programs at Kempsey</td>
<td>Jacqui Woon</td>
<td>Clinical Nurse Consultant</td>
</tr>
</tbody>
</table>
### Executive Modular CLP – May 2010 Intake

<table>
<thead>
<tr>
<th>Project Title</th>
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</tr>
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<tbody>
<tr>
<td>Improving Time to PCI (Percutaneous Coronary Intervention) in patients with STEMIs (ST Elevation Myocardial Infarction)</td>
<td>Paul Fischer</td>
<td>Acting Director, ED</td>
</tr>
<tr>
<td>“A Broken Dream” – Reducing Patient Waiting Times</td>
<td>Pam Lane</td>
<td>Senior Physiotherapist</td>
</tr>
<tr>
<td>Improving Patient Safety During Peri-procedure Care</td>
<td>Brian Pezzutti</td>
<td>Director of Anaesthetics and Peri-operative Care</td>
</tr>
<tr>
<td>Senior Medical Review of ATS Category 2 Patients prior to Discharge from the Ed</td>
<td>Paul Spillane</td>
<td>Senior Staff Specialist / DMT ED</td>
</tr>
</tbody>
</table>

### Northern Sydney Central Coast Area Health Service

#### Foundational Statewide CLP

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Creating hEAPs of Beds” (EAP: Emergency Access Performance)</td>
<td>Suzanne Bearup</td>
<td>Acting Deputy Director of Nursing, Mona Vale Hospital</td>
</tr>
<tr>
<td>Discharge Planning and Patient Access</td>
<td>Rowena Broadbent</td>
<td>Nursing Unit Manager, Royal North Shore Hospital</td>
</tr>
<tr>
<td>Reducing the Risk of Further Fragility Fractures in Patients over 65yrs Discharged from the Emergency Department</td>
<td>Fiona Cameron</td>
<td>ASET Clinical Nurse Consultant, Co-ordinates Aged Service Emergency Team, Mona Vale Hospital</td>
</tr>
<tr>
<td>Grand Designs: Redesign of the Dispensary Work Processes</td>
<td>Cassie Fersterer</td>
<td>Dispensary Manager, Royal North Shore Hospital</td>
</tr>
<tr>
<td>Communication and a New Way Forward for the Social Work Team</td>
<td>Kerry Griffith</td>
<td>Manager, Northern Beaches Social Work Department</td>
</tr>
<tr>
<td>Weight for Change - Weighing Patients in the Emergency Department</td>
<td>Gwen Hickey</td>
<td>Deputy Manager, Nutrition Services, Royal North Shore Hospital</td>
</tr>
<tr>
<td>Review of the Youth Mental Health Clinical Review Processes</td>
<td>Belinda Hodges</td>
<td>Youth Mental Health Team Leader / Case Manager</td>
</tr>
<tr>
<td>“Knocking out the Kids” General Anaesthetic Referral Process</td>
<td>Baden Hunter</td>
<td>Principal Oral Health Therapist</td>
</tr>
<tr>
<td>Ensuring the Appropriate Availability of Pre-packed Medication in the Hospital</td>
<td>Michelle Jeffery</td>
<td>Acting Deputy Director of Pharmacy, Royal North Shore Hospital</td>
</tr>
<tr>
<td>Management Plans for Complex Mental Health Consumers</td>
<td>Peter Kerle</td>
<td>Senior Social Worker, Central Coast Mental Health</td>
</tr>
<tr>
<td>“A Breath of Fresh Air” Ensuring Anaesthetic Machines are Serviced Appropriately</td>
<td>Karen Kidd</td>
<td>Clinical Nursing Unit Manager, Operating Theatres</td>
</tr>
<tr>
<td>Improving Patient Care and Outcomes within the Medical Assessment Unit (MAU) Medical Assessment Unit Emergency Department</td>
<td>Terena McIntosh</td>
<td>Nursing Unit Manager, Medical Assessment Unit, Royal North Shore Hospital</td>
</tr>
<tr>
<td>To Improve Compliance with Completion of the Malnutrition Screening Tool (MST) on the Multidisciplinary Admission Form (MDAF)</td>
<td>Radha Murthi</td>
<td>Manager Nutrition and Dietetics Department, Ryde Hospital</td>
</tr>
<tr>
<td>Role Clarification and Responsibilities for a Stomal Therapy Clinical Nurse Consultant</td>
<td>Susan Julia Strizic</td>
<td>Acting Clinical Nurse Consultant, Stomal Therapist / Wounds</td>
</tr>
<tr>
<td>Getting Word Out Sooner: Reducing the Duration Between the Discharge of a Family and the Completion of the Admission Summary Report</td>
<td>Matthew Symond</td>
<td>Clinical Psychologist</td>
</tr>
</tbody>
</table>
### Designing an Appropriate Clinical Education Program for Nurses

Steve Tkaczyk, Clinical Nurse Specialist, Lindsay Madew Unit

### MRI Guided Brachytherapy (MR-IGBT) Treatment Pathway for Cancer of the Uterine Cervix

Di Van der Saag, Nursing Unit Manager, Radio-oncology, Royal North Shore Hospital

### “Bag Full of Medicine” Ensuring RNs Have an Emergency Drug Kit when in the Community

Jane Whitehurst, Clinical Nurse Consultant, Acute/Post-acute Care

### Reflect and Deliver: Improvement of Communication of Midwifery Care using Reflective Practice

Sarah Winter, Acting Nurse Unit Manager, Delivery Suite, Royal North Shore Hospital

### Improving Adherence to NSW Health Cardiac Monitoring Policy

Linda Woollard, Clinical Nurse Consultant, Cardiac Services

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### Executive Modular CLP – May 2010 Intake

<table>
<thead>
<tr>
<th>Project Title</th>
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</thead>
<tbody>
<tr>
<td>Baby Breath: Reducing Mechanical Ventilation Days in Premature Neonates</td>
<td>Jennifer Bowen</td>
<td>Senior Staff Specialist, Neonatology</td>
</tr>
<tr>
<td>Mother’s Choice - Introduction of Midwifery Group Practice Model of Care into the Northern Beaches Maternity Services</td>
<td>Heather Gough</td>
<td>Divisional Manager</td>
</tr>
<tr>
<td>Wyong Psychiatric Emergency Care Centre (PEC) and Emergency Department Joint Patient Management Project</td>
<td>Mark Joyce</td>
<td>Nurse Unit Manager, Mental Health</td>
</tr>
<tr>
<td>Ready, Steady, Go! COPD action plans</td>
<td>Paul Roach</td>
<td>Respiratory and General Physician</td>
</tr>
</tbody>
</table>

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### South Eastern Sydney Illawarra Area Health Service

#### Foundational Statewide CLP

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing the Number of “Day-of-Surgery Cancellations” at Shellharbour Public Hospital.</td>
<td>Justin Dixon, Heidi Epps, Angela Jones, Barbara Kennard, Angela Jones</td>
<td>Deputy Chief Radiation Therapist, Clinical Nurse Specialist, Nurse Unit Manager, Chief Pharmacist, Midwifery Unit Manager</td>
</tr>
<tr>
<td>Multidisciplinary Clinical Handover</td>
<td>Renee Fortunato</td>
<td>Unit Head, Physiotherapist</td>
</tr>
<tr>
<td>Doctor Who? Linking Child &amp; Adolescent Mental Health Consumers with General Practitioners (GPs)</td>
<td>Linda Green</td>
<td>Project Co-ordinator, Adult Community Mental Health Redesign</td>
</tr>
<tr>
<td>Making Best Bladder Care Easy</td>
<td>Emma Knowland</td>
<td>Clinical Nurse Educator</td>
</tr>
<tr>
<td>Enhancing the Paediatric MRI Journey at Sydney Children’s Hospital, Randwick</td>
<td>Cathy Lovell, Michelle Perrin</td>
<td>Clinical Director, Department Head, Recreation and Play Therapy</td>
</tr>
<tr>
<td>To Improve Timely Assessment and Management of Risk for Patients on Admission</td>
<td>Belinda Rabet</td>
<td>Nursing Unit Manager</td>
</tr>
<tr>
<td>Spacers Versus Nebulisers, Prince of Wales Emergency Department</td>
<td>Elizabeth Ryan</td>
<td>Nurse Unit Manager</td>
</tr>
<tr>
<td>Implementation of Managed Care Program in Oral Health</td>
<td>Geetanjali Salwan</td>
<td>Senior Dental Officer</td>
</tr>
<tr>
<td>Reducing the Length of Stay of Post-operative Back Surgery Patients</td>
<td>Helen Tassell</td>
<td>Senior Physiotherapist, Neurosciences Unit</td>
</tr>
</tbody>
</table>
### Clinical Leadership Program

**Health Screening for Refugee Youth**
Lisa Woodland  | Learning, Research & Workforce Development and Refugee Health Program Manager

**Patients Need to be at the Centre of our Universe**
Peggy Yeomans  | Aged Care Team Leader, Social Work.

### Executive Modular CLP – May 2010 Intake

<table>
<thead>
<tr>
<th>Project Title</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Shared-care Management of Fever and Neutropenia in Children with Cancer</td>
<td>Richard Cohn</td>
<td>Clinical Director, Medicine</td>
</tr>
<tr>
<td>Improving ED Processing Time</td>
<td>David Mah</td>
<td>Director of Emergency Medicine Training</td>
</tr>
<tr>
<td>Improving the Warfarin Initiation Process</td>
<td>William Pratt</td>
<td>Staff Specialist Physician</td>
</tr>
<tr>
<td>Improving Family Notification of a Hereditary Cancer Syndrome</td>
<td>Katherine Tucker</td>
<td>Head of Hereditary Cancer Clinic</td>
</tr>
</tbody>
</table>

### Sydney South West Area Health Service

**Executive Modular CLP – May 2010 Intake**

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using Data to Identify and Manage Clinical Risk After Hours</td>
<td>Anna Chapman</td>
<td>Director of Nursing and Midwifery Services</td>
</tr>
<tr>
<td>Improving the Implementation of RCA Recommendations in a Mental Health Service</td>
<td>Paul Clenaghan</td>
<td>NE Cluster Manager, Mental Health</td>
</tr>
<tr>
<td>Measure to Manage - Emergency Radiology</td>
<td>Richard Cracknell</td>
<td>Director of Emergency Department</td>
</tr>
</tbody>
</table>

### Sydney West Area Health Service

**Foundational Statewide CLP**

<table>
<thead>
<tr>
<th>Project Title</th>
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<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linking Mental and Physical Health Care for Mental Health Consumers</td>
<td>Michael Adamantidis</td>
<td>Team Leader, BMDH Psychiatry</td>
</tr>
<tr>
<td></td>
<td>Rhonda Beach</td>
<td>Clinical Nurse Specialist, Clozapine Co-ordinator &amp; GP Liaison</td>
</tr>
<tr>
<td></td>
<td>Jennifer McIntyre</td>
<td>Registered Nurse, Blacktown AAMHT</td>
</tr>
<tr>
<td>Nicotine Replacement Therapy: Promoting Compliance with Co-morbid Substance Dependence</td>
<td>Rebecca Burrows</td>
<td>Registered Nurse, Drug &amp;Alcohol, Nepean</td>
</tr>
<tr>
<td></td>
<td>Aliza Freeman</td>
<td>Registered Nurse /Team Leader, Drug &amp; Alcohol, Nepean</td>
</tr>
<tr>
<td>Completing the Circle – Incident Management on Ward 4C</td>
<td>Sharryn Byers</td>
<td>Clinical Nurse Consultant, Neurosurgery, Nepean</td>
</tr>
<tr>
<td>Vene-puncture, Peripheral Cannulation and Sphygmomanometer Procedures on Limbs with Compromised Vascular Function: Preventable Practice?</td>
<td>Dr Sharon Chen</td>
<td>Senior Staff Specialist, Infectious Diseases, Westmead</td>
</tr>
<tr>
<td></td>
<td>Linda Collins</td>
<td>Clinical Nurse Educator, B3 Surgical, Westmead</td>
</tr>
<tr>
<td></td>
<td>Jane Sinclair</td>
<td>Clinical Nurse Educator / Clinical Nurse Specialist, Surgical High-dependency, Westmead</td>
</tr>
<tr>
<td>Project Listing</td>
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<tr>
<td><strong>A Breath of Fresh Air: Integrating Allied Health into the Management of Lung Cancer</strong></td>
<td>Jacqui Hampton</td>
<td>Senior Dietitian, Oncology, Nepean</td>
</tr>
<tr>
<td></td>
<td>Laura Kirsten</td>
<td>Clinical Psychologist, Cancer Centre, Nepean</td>
</tr>
<tr>
<td></td>
<td>Dawn Hutley</td>
<td>A/Senior OT, Cancer Care, Nepean</td>
</tr>
<tr>
<td><strong>Provide a Co-ordinated Mental Health Consultation Service for Women in the Perinatal Period</strong></td>
<td>Jean Hawkins</td>
<td>Clinical Nurse Consultant, Consultation Liaison Psychiatry, Blacktown</td>
</tr>
<tr>
<td><strong>Jaundice in the Newborn: Providing Consistent Information and Care</strong></td>
<td>Barbara Jolley</td>
<td>Clinical Nurse Consultant, NICU, Nepean</td>
</tr>
<tr>
<td></td>
<td>Christine Sulfaro</td>
<td>A/ Nurse Unit Manager, Children's Ward, Nepean</td>
</tr>
<tr>
<td><strong>Streamlining New Client Referrals for the Nepean Diabetes Service</strong></td>
<td>Julie Longson</td>
<td>Diabetes Educator, Nepean</td>
</tr>
<tr>
<td><strong>Ambulatory Diabetes Care for Newly Diagnosed Paediatric Patients</strong></td>
<td>Anne Marks</td>
<td>Clinical Nurse Consultant, Paediatric Diabetes, Nepean</td>
</tr>
<tr>
<td><strong>ED Short-stay Unit</strong></td>
<td>Satish Mitter</td>
<td>Staff Specialist, Emergency Medicine, BMDH</td>
</tr>
<tr>
<td><strong>Observational Study to Review Processes and Compliance With Area Policy for the Administration of SBD Drugs</strong></td>
<td>Matthew Rimmington</td>
<td>Clinical Nurse Specialist / Clinical Nurse Educator, Anaesthetics / Recovery, Nepean</td>
</tr>
<tr>
<td><strong>To Prepare Delivery Suite at Nepean Hospital to Comply with all Standards of the Baby Friendly Health Initiative (BFHI)</strong></td>
<td>Therese Ross</td>
<td>Midwife/Acting NUM, Delivery Suite / ANC, Nepean</td>
</tr>
<tr>
<td><strong>Improving the Participation Rate of Women entering into the BreastScreen NSW Sydney West Program</strong></td>
<td>Vanessa Sands</td>
<td>Transition Manager, BCI Sunflower Clinics – Westmead</td>
</tr>
<tr>
<td><strong>Starving for Attention – Malnutrition Screening of Inpatients: a Pilot Program</strong></td>
<td>Melanie Schier</td>
<td>A/Dept Head, Nutrition &amp; Dietetics, BMDH</td>
</tr>
<tr>
<td><strong>Case Formulation in CAMHS as Minimum Standard</strong></td>
<td>Samina Whale</td>
<td>Clinical Psychologist, Child &amp; Adolescent Mental Health, Western Cluster</td>
</tr>
</tbody>
</table>

**Executive Modular CLP – May 2010 Intake**

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<tbody>
<tr>
<td>Increase the Attendance on the Day of Surgery</td>
<td>Helen Currow</td>
<td>Head of Department – Anaesthesia</td>
</tr>
<tr>
<td>Improving Length of Stays in Patients with Community Acquired Pneumonia</td>
<td>Peter Wu</td>
<td>Respiratory Physician</td>
</tr>
</tbody>
</table>
Acknowledgements

CLP Executive (Modular) Program Sponsors – 2010

Graeme Malone Ambulance Service of NSW
Frank Horn Children’s Hospital at Westmead
Susan Weisser, Ken Hampson Greater Southern
Jenny McParlane Greater Western
Kim Hill Hunter New England
Alison Stevens Justice Health Service
Helen Parson Justice Health Service
Janne Boot North Coast
Susan Pearce Northern Sydney Central Coast
Lynda-Mary Wood Northern Sydney Central Coast
Gerard Rooney South Eastern Sydney Illawarra
Paul Gavel Sydney South West
Jeanette Sheridan Sydney West

CLP External Faculty 2010

Gabrielle Droulers Centre for Career Development
Avril Henry Avril Henry Pty Ltd
Liz Mullins Mullins Health Consulting
Mark O’Brien Cognitive Institute
Philip Pogson The Leading Partnership
Paul Vorbach Academy Global
Simon Willcock University of Sydney

CLP Foundational (Statewide) Program Sponsors – 2010

Valerie Wilson Children’s Hospital at Westmead
Frank Horn Children’s Hospital at Westmead
Maggie Crowley Greater Southern
Jacqui Blackshaw Greater Western
Nerida Barton Hunter New England
Alison Stevens Justice Health Service

Katie Willey North Coast
Lynda-Mary Wood Northern Sydney Central Coast
Kim Olesen, Jacqui Cross South Eastern Sydney Illawarra
Brenda Bradbery, Sue Whitby Sydney West

CLP Foundational (Statewide) Facilitators / Program Managers – 2010

Helen O’Grady Children’s Hospital at Westmead
Rachel Primrose Children’s Hospital at Westmead
Amanda Baker, Conie Bostock Greater Southern
Vicki Scott, Marion Seers Greater Western
Anne Mason, Linda Ritchard Hunter New England
Julie Skinner Justice Health Service
Karen Wickham, Rod Peardon, Malcolm Brown North Coast
Mary Lambell, Peter Short Northern Sydney Central Coast
Sheree Paterson South Eastern Sydney Illawarra
Richard Tewson, Johanna Denis Sydney West

CLP Program Leaders – 2010

Bernie Harrison Director Clinical Leadership Development and Training, CEC
Colleen Leathley Co-ordinator Foundational (Statewide) Clinical Leadership Program, CEC

Compiled and edited by

Bernie Harrison Director, Clinical Leadership Development and Training, CEC
Brid Morahan Consultant, Editproof
Rachel Primrose Co-ordinator, Clinical Leadership Program, CEC
Cathy Vinters Program Leader, Clinical Practice Improvement Training, CEC
Kay Wright Program Support Officer Clinical Leadership Program, CEC
What the participants said about the program

Executive (Modular) Program:

“I have a greater understanding of my strengths and weaknesses, how I influence the people around me and how this impacts on work dynamics and the delivery of better outcomes. I have the confidence to undertake a quality improvement project. I can make a real difference. This course provided me with the skills to do this.”

“The program has helped to improve my ability to work with multidisciplinary groups, including ways to involve ‘hands on’ clinicians with quality improvement projects.”

“Through the program I have gained an increased awareness of processes designed to enhance the practice of clinical change and redesign to achieve a successful outcome. I now experience improved engagement of staff in the change process.”

Foundational (Statewide) Program:

“The program enabled me to really focus my attention on the changes I wanted to see both in myself and my team and to explore a host of alternative strategies to achieve those changes. I am much better at critical reflection and change management in my daily practice as a direct result of completing the portfolio.”

“Since completing the program I feel I am better equipped to lead my team and am working with the team to improve its effectiveness. I am leading the way to better care delivery and a happier work environment.”

Some other words from participants:

Empowering, informative, inspiring, innovative, challenging, rewarding, interactive, supportive, stimulating.
If you would like more information about the Clinical Leadership Program or further details about any of the projects please contact:

Clinical Excellence Commission
Locked Bag A4062
Sydney South NSW 1235

Tel: (02) 9269 5500
Fax: (02) 9269 5599

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