EXECUTIVE CLINICAL LEADERSHIP PROGRAM

Cohort 20 Graduate Posters Part 2
Aim Statement:
To reduce waiting times for patients triaged with dental pain on 3b waiting list from 7 months to 1 month by January 2019

Background to problem worth solving
• The recommended maximum waiting time for patients on 3b waiting list is supposed to be one month as stipulated by the POHP policy.
• In October 2017, it was observed that there was a spike in the number of patients waiting on the 3b waiting list resulting in the increase of waiting times to 7 months instead of the recommended 1 month. This was attributed to the reduced funds for the financial year 2017/2018, as well as introduction of the new oral health electronic files system.

Driver Diagram

Results continued

<table>
<thead>
<tr>
<th>Results</th>
<th>Process measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in total number of patients waiting on 3b waiting list from 1624 to 103 over a period of 9 months</td>
<td></td>
</tr>
<tr>
<td>Reduction in waiting time for 3b patients from 7 months to 1 month by January 2019</td>
<td></td>
</tr>
</tbody>
</table>

Team members

Sponsors
Claire Phelan, Director Oral Health SESLHD Dr Lanny Chor, Chief Dentist NSW

Project Team
• Team Leader – Dr Maggie Ibrahim, Lead Dental Officer
• Dr Mark O’Connor Director Oral Health ISLHD
• QI Advisor – Josie Julian
• Consumer – Darrel Foster
• Patient Flow Officer - Gail Brennan
• Information Manager: Andja Rezo
• Senior dental Officer TSH Dr Bhakti Sakaria
• A/Senior Dental Officer HADC Dr Monique Luthra
• OHFFS coordinator Elizabeth Levin

Team Members:
• Team leader – Dr Maggie Ibrahim – Lead Dental Officer
• Consumer – Darrel Foster
• QI Advisor – Josie Julian
• Information Manager: Andja Rezo
• Patient Flow Officer: Gail Brennan
• Patient Officer: Luthra

Literature review
• Priority Oral Health Program (POHP) and List Management PD2017_023

Change concept 1 - PDSA Cycle

Testing a Change Idea via a PDSA Cycle:
Testing the change of introducing an appointment book set up as per each clinic needs instead of one-size-fits-all

Change concept 2 - PDSA Cycle

Testing a Change Idea via a PDSA Cycle:
Testing the change of importing appointment book set up as per each clinic needs instead of one-size-fits-all

Change concept 3 - PDSA Cycle

Testing a Change Idea via a PDSA Cycle:
Testing the change of introducing an appointment book set up as per each clinic needs instead of one-size-fits-all

Overall outcome of project:
• Reduction of waiting times for 3b patients from 8 months to 1 month except for patients waiting on interpreter appointments 2 months.
• Reduction in patients waiting with pain on 3b waiting list from 1624 to 103
• Reduction in unclaimed vouchers giving the service more control over the budget planning and spending

Cost savings:
• Utilising the whole dental team following the assessments, with the dental officers managing the less complex cases.
• Management of the less complex procedures, the Oral Health Therapist and Hygienists managing the less complex cases.
• Clinical assessments allow the opportunity to extend voucher limit

Plans to sustain changes and hold the gains
• Changing appointment books across all clinics to reflect the new model of service.
• All patients receiving vouchers off the 3b waiting list are to receive a 10 minutes appointment for clinical assessment.
• A system is in place to regularly audit and audit the waiting list.
• Continuous monitoring of resources versus demands and modify the model of service delivery accordingly.
• Continuous to seek staff feedback, and share the results of the any quality improvement activity with them.

Planned:
• Mid point project presentation to SESLHD Oral Health team
• Mid point project presentation to State Oral Health Executive Committee as requested by Chief dental NSW
• Presenting to ISLHD Oral Health Services on their staff development day.
• Enters a Bright Spot Poster SESLHD DEC 2018

ECLP Cohort20

Primary Drivers

1. Redesign appointment template
   • Increase number of slots in booking template to allow for a more efficient use of waiting time

2. Central intake
   • Priorise patients to be seen by the FOCC and to be triaged

Secondary Drivers

1. Patients factors
   • Prioritise patients for clinical assessment

2. Process
   • Improve patient education and awareness of times and expectations

Results

Outcome measures

<table>
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<tr>
<td>Reduction in longest wait for 3b at HURS-COM</td>
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• A system is in place to regularly audit and audit the waiting list.
• Continuous monitoring of resources versus demands and modify the model of service delivery accordingly.
• Continuous to seek staff feedback, and share the results of the any quality improvement activity with them.
• Continuous to educate patients and private providers on the new adopted change

Planned:
• Mid point project presentation to SESLHD Oral Health team
• Mid point project presentation to State Oral Health Executive Committee as requested by Chief dental NSW
• Presenting to ISLHD Oral Health Services on their staff development day.
• Enters a Bright Spot Poster SESLHD DEC 2018

ECLP Cohort20
A Partnership Project to Reduce Silos and Improve the Health Outcomes for All Patients with ATOD Disorders at Leeton Hospital.

**Aim Statement:** By Jan 2019 80% of admitted patients (14 years +) will have an Alcohol, Tobacco and Other Drug (ATOD) Assessment completed at Leeton Hospital.

**Background to problem worth solving:**
- MLHD “Quality Auditing Reporting System” (QARS) identified an ‘ad hoc’ approach to Substance Use Risk Assessments.
- The societal cost of alcohol misuse in Australia is more than $14 billion, of which $1.6 billion is related to the healthcare costs of patients.
- MLHD Clinical Reviews identify significant delays in assessment, medical treatment and medication administration resulting a longer stay in hospital and poorer health outcomes (death) (particularly for Indigenous people).

**Driver Diagram**

**Primary Drivers**
- Increasing Patient Engagement
  - Process Measure: How much? 80% by end Dec 2018
- Increasing Staff Engagement
  - Process Measure: How much? 80% by end Dec 2018
- Improving in the process and tools
  - Process Measure: How much? 80% by end Dec 2018

**Secondary Drivers**
- Increase patient / carer participation in decision making
- Increase patient sense of safety
- Reduce likelihood of patient self-discharging
- Increase staff capacity / capability – upskilling
- Increase in the number of patients identified and treated early
- Substantial increase in patients identified with ATOD
- Increase in staffs ATOD knowledge base
- Include in the early identification & Treatment of ATOD patients
- Clearly define roles and responsibilities
- Improvement engagement with patient family and carers
- Improved flagging of patients not ATOD assessed at triage

**Change Ideas**
- ED for consumer rep
- Staff to lower voice when asking ATOD questions
- Inform patients of ATOD project
- Provide ATOD patient / carer education
- Provide staff with introductory ATOD guide
- Staff to ask all patients if they are ATOD questions
- Share with staff improvement in clinical practice
- Share with patient feedback
- Identify ATOD champions
- Provide staff with ATOD procedure (booklet)
- Provide QARS or staff self as go to person
- Project team to share project info with other staff
- Provide patient / family & staff with project transparency increased engagement
- Share with staff reduction in Injury / Clinical reviews
- Early ATOD identification & Treatment improves patient flow & LOS
- Increase ATOD self-assessment
- Staff engaged patient & family in their care

**Process Measures:**
- Ongoing staff ATOD training
- Access to ATOD resources
- Staff AOD Brochure

**Outcome Measures**
- Early ATOD identification and treatment by nursing staff
- Reduced adverse incidents
- Staff understood the why
- Therefore more willing to engage in the process.
- Staff understood the project within Leeton hospital.

**Results – Pre (baseline)**
- MLHD “Quality Auditing Reporting System” (QARS) identified an ‘ad hoc’ approach to Substance Use Risk Assessments.
- MLHD Clinical Reviews identify significant delays in assessment, medical treatment and medication administration resulting a longer stay in hospital and poorer health outcomes (death) (particularly for Indigenous people).
- Drug and alcohol issues are a key factor in behavioural incidents in hospitals.

**Plan, Do, Study, Act (PDSA) Cycles:**

**Team Members:**
- **Sponsors** - Director MLHD Robyn Manzie, MLHD Manager Graham Garland, MLHD Director Clinical Governance Unit Jill Reymant.
- **Team Leader** Martina Greenaway
- **Project Team Leeton Hospital:**
  - Amber Thomborrowsu Melissa Sinclair
  - Christine Hidditch, Chloe McGraft
  - Rebecca Fohmsbee
  - Chipo Mumbure
  - Stephanie Hanlon
  - Kerry Maguire
  - Dr Tatiana Pavlovskaya
  - Dr Malith Raminathan.
  - Pharmacist: Jeanine Delemare & Melissa District Coordinator Aboriginal Coordinator.

**Literature Review:**
- Effectiveness of Alcohol and Other Drug interventions in at risk Aboriginal youth (2017)
- The Hospital & D&A Consultation Liaison Model of Care (2015)

**Achieved!**

**Strategies for Spreading:**
- Submit to ACI / CEC Innovation Exchange.
- Submit to MLHD Excellence Awards 2019
- Continue working with MLHD, MPHN and CGU continuing to spread the word.
**Overcrowding in Paediatric Emergency**

**Aim Statement:**
By January 2020, the average time spent by children attending ED at Children's Hospital at Westmead will be reduced by 50%.

**Background to problem worth solving**
Overcrowding is one of the leading problems and one of the most common patient safety risks identified in the ED.

**ED performance (ETP) at CHW demonstrates marked seasonal variation; overall performance is well below target levels, with further deterioration in 2018.**

**Team members**
- **Sponsors**
  - Dr Joanne Ging (SCHN Acting DCO)
  - Dr Glen Farrow (SCHN DCG)
- **Project Team**
  - Team Leader – Dr Marino Festa
  - Rebecca Nogajski, CHW ED Medical HoD
  - Nadine Mari, Dominic Sertori, CHW ED TL
  - Luke Moriarty, CHW AHINM
  - Sarah Wood, CHW Patient Flow Manager
  - Armanda Marston, CHW ED Fellow
  - Sharon Roumanos, SCHN Clinical Redesign
  - QI Advisor – Chrsly Ceely, SCHN
  - Consumers – CHW ED Consumer Advisory Group

**Link to National Strategic Imperative**
- Australasian College for Emergency Medicine’s Statement on emergency department overcrowding revised 2018

**Literature review**
- Boyle A et al. Emergency department crowding: time for interventions and policy evaluations 2012
- Trzcinski S et al. ED overcrowding in the US: an emerging threat to patient safety and public health 2003
- Latovich D, Hirsch R. Entry overload, emergency department overcrowding, and ambulance bypass 2003
- Richardson D. Increase in patient mortality at 10 days associated with ED overcrowding 2006

**Change concepts:**
- **Diagnostic Data:**

**PDSA Cycle 1**
First Change Idea tested via a PDSA Cycle: ED Senior Early Assessment (SEA) for patients streamed to Acute Assessment Area (previously known as Cubby)

**Results**
Main Outcome and Process Measures

**Discussion**
We hypothesised a direct link between overcrowding and ETP: this QI project is aimed at reducing time spent in ED for all patients.

ED attendances fluctuate between summer and winter seasons. This is reflected in seasonal variation in ETP. Daily ED admission and discharge times are also markedly out of phase.

**Overall Outcome of Project:**
Intrinsic complexity and variations in ED presentations and performance have required a significant period of time for diagnostic data to be collected and analysed.

The first major change, not tested in a PDSA was to challenge ED norms and existing CHW dogma. Improved understanding of the process of care has led to significant progress in Hospital language, culture, ownership and accountability.

**Plans to sustain and share change**
FirstNet data capture and reporting will be standardised across both EDs in SCHN. PDSA cycles will continue alongside clinical redesign in ED, medical, surgical and patient flow areas.
Reduction in CT performance times from ED

Author: Pat Redmond Position: Assistant Manager of Medical Imaging – Monaro
Email: pat.redmond@health.nsw.gov.au Phone: 02 6455 3225

Aim statement: To have 90% of diagnostic CTs requested by ED during business hours performed within defined time periods by January 2019.

Abdo CTs: 90 minutes
Non-abdo CTs: 60 minutes

Background: Imaging delays can have an impact on ETP targets. This is particularly true for CTs, which generated the bulk of delays for our site. In addition, delays of diagnosis will delay treatment, which may impact on patient care.

Project team:
Pat Redmond – Project Lead
Kirsti Dixon – Nurse Manager
Jo Caldwell – ED NUM
Ceara Collins – CT Senior
Ellie O’Keefe – Radiographer

Results:

Planning PDSA Cycles to test Change Ideas

Outcome of project:
There was significant reduction of delays, particularly for CT abdo studies. We were able to meet the target for two months for abdo CTs, however we were unable to meet the KPI for non-abdo CTs. Performance reduced around September due to position changes, but has jumped up again.

Plans to sustain change:
• Regularly review statistics and track results
• Discuss with staff at monthly meetings
• Monitor delay drivers and work to remove
Improving ferritin testing result management

Dr Amanda Allen – Lead Medical Officer (Queensland)
E: AAllen@redcrossblood.org.au  P: 07 3838 8219
Patrick Harper – Project Coordinator / Business Process Analyst
E: ppharper@redcrossblood.org.au  P: 08 6213 5912
Australian Red Cross Blood Service

AIM STATEMENT
Increase the number of correctly processed ferritin test results to 100% by end December 2018.

- All donors are tested for haemoglobin levels via either capillary and/or venous haemoglobin testing.
- Ferritin tests are frequently ordered incorrectly by staff in donor centres or are missed.
- Erroneous ‘ferritin untested’ letters are generated which require time-consuming investigation and rework by Medical Services, Donor Services and Manufacturing staff.

BASELINE DATA
Data analysis via Pareto Chart identified 3 key areas to focus change ideas:

- Results indicate that change efforts relating to training have had limited impact in reducing errors.
- Change efforts relating to the National Blood Management System appear positive based on early ferritin error data indications.

DISCUSSION

SUSTAINING CHANGE
- Ongoing monitoring of the issues will be required to see if sustained change has been achieved.
- Further changes to the technical questionnaire wording are already planned (long lead time).
- Reinforce training for targeted donor centres with consistently high error rates.
- Review remaining issues (e.g. plasma centre NBMS build) to address.

Australian governments fund the Australian Red Cross Blood Service to provide blood, blood products and services to the Australian community.
Improving Bone Marrow Donor Recruitment in Blood Donor Centres

Aim Statement
Within 6 months of project commencement, donors recruited through the pilot blood donor centres will be at least 60% male, with an average age under 30 years.

Background
The “ideal” bone marrow donor is a healthy, young male
- Young: younger donor cells have a better clinical outcome for the recipient
- Male: clinicians tend to favour male donors, due to improved donor availability compared to females (pregnancy/breastfeeding), and clinical factors such as the likelihood of larger donation cell counts (as male donors are generally physically larger)

Donors recruited to the Australian Bone Marrow Donor Registry (ABMDR) through blood donor centres during 2017-18 were only 32% male, and had an average age of 32 years.

Team Members
Sponsor:
- Andrew Scott: Donor Experience & Transformation Manager

Project Team:
- Paul Berghofer: Donor Services Bone Marrow and Change Manager
- Maria Nikolakopoulos: Bone Marrow Donor Coordinator
- Susan Dawson: Bone Marrow Donor Coordinator
- John Bain: Blood Donor Centre Manager
- David Todd: Blood Donor Centre Manager
- Maureen Stacy: Blood Donor Centre Manager
- Jennifer Rush: Blood Donor Centre Manager
- DB: Volunteer donor

Link to Strategic Imperative
The Blood Service’s 2018-19 Business Plan outlines 3 strategic pillars; Improve, Build and Grow.
This project aligns with the Improve strategic pillar, and specifically with the goal to create an “optimised donor panel and service excellence”.

Literature review

Proposed PDSA Cycles

Discussion and Outcome
- Stretch goals for percentage of donors recruited that were male, and average donor age were met immediately following implementation of the first PDSA cycle
- Implementation, donors recruited were 84.6% male, and had an average age of 28.3 years.
- The project also had the unintended effect of increasing overall recruitment numbers. This will need to be monitored due to funding implications. (The project aim was to improve targeted recruitment, not to cause a net increase in recruitment activity)
- A decision will be made as to whether there would be a return on investment from implementing further PDSA cycles (80:20 rule)
- Focus will be on sustainability and scaling up
- If scaled up and sustained, the benefits of this project will be:
  - More young male donors on the volunteer registry
  - More ideal donors found within Australia for patients requiring transplants
  - Faster/easier access to these donors results in better transplant outcomes
  - The Commonwealth Government funds the program to source suitable bone marrow donors from overseas
- Less reliance on overseas donors = significant cost savings to this program

Plans to Sustain Change
- Re-engage the Blood Service National Call Centre to roll this out at scale
- Write into standard operating procedures
- Implement more rigorous monitoring and reporting of recruitment metrics, and share with those responsible for carrying out these new procedures
- Monitor for and report flow on clinical impacts eg. increase in number of Australian patients transplanted from Australian donors
- Celebrate successes
Standardisation of an RMO Education program within ED term Rotations

Author: Dr R McMahon; Position: DEMT, Gosford Hospital; Email: Robert.mcmahon@health.nsw.gov.au; Phone: (02) 43203569
ECLP Cohort 20

Aim Statement:
To increase RMO education session access from a baseline of approximately 15%, up to 50% of available sessions by the end of the 2018/9 academic year.

Background to problem worth solving:
1. Lack of standardised education program for prevocational doctors rotating through an ED term - Term feedback from RMOs reflecting a need for an improved education program.
2. Established standards and guidelines from HETI for need for structured continuous education programs to meet training needs of junior doctors.
3. Need to comply with the Australian Medical Board recommendations for Intern training.
4. Local General Clinical Training Committee (GCTC) review of current training systems highlighted need for improved departmental RMO teaching programs.
5. Many overseas trained junior doctors starting work in Australia end up working in ED without a firm grounding of Australian health care practices and so ED terms offer an opportunity to teach & train these doctors about medical practice in the Australian system.

Team members:

Sponsor/s (Guidance Team):
- Dr Kate Porges, Area Director of Emergency Services, CCLHD
- Dr Philippa Keir, Director of Emergency Department, Gosford Hospital
- Gosford Hospital Medical Workforce & Education Unit (MWEU)
- Dr Julian Willcocks – Director of Prevocational Education & Training (DPET) – Gosford Hospital

Project Team:
- Team Leader – Dr R McMahon
- QI Advisor – Ms Clare Karibika
- Consumer – CCLHD RMO group

Driver Diagram

The Problem:
Need to improve standardisation of and access to education sessions for RMOs undertaking ED term in a public teaching hospital.

Aim to increase the average number of ED RMO Education sessions attended at Gosford ED from 12% up to 50% per term, by the end of the 2018/9 academic year.

Team Members:
- Project Sponsor – Dr R McMahon
- Project Leader – Dr R McMahon
- Team Leader – Dr R McMahon
- QI Advisor – Ms Clare Karibika
- Consumer – Dr Kate Porges
- Team Support – Dr D. Willcocks

Primary Drivers
- A Standardised Process
  - Process Measure: [Redacted]

Secondary Drivers
- Improve resource
  - Resource Measure: [Redacted]

Change Ideas

Primary Change Ideas
- Change Ideas
  - Process
  - Resource
  - Balancing

Priority Change Ideas

Priority Change Ideas
- Priority Change Ideas
  - Process
  - Resource
  - Balancing

Results

Outcome measures (Pending implementation)

Process measures (Pending implementation)

Balancing measures (Pending implementation)

Discussion (Pending implementation)

Plans to sustain change
- Assigning responsibility for RMO education to ED SS as formal and ongoing non-clinical portfolio.
- Advertisement of education program during recruitment drives to attract new staff.
- Involvement of Registrar group in continuous development and teaching delivery

Plans to spread/share change

Consider further development and spreading through and with assistance of HETI once new process becomes established and data gathered to show benefit.

Link to National Standard or Strategic Imperative – State and National training standards for interns & prevocational doctors in the workplace


Overall Outcome of Project:

Implementation pending

Associated Benefit:

Potential increased interest in Emergency Medicine for RMOs participating in the program and knock on recruitment and staffing benefits
Reduction of seclusion episodes by 50%

Aim Statement:
To reduce seclusion episodes by 50% in an acute mental health unit.

The reduction of seclusion was obtained through early detection and organised management plans to reduce escalation of aggression.

Team members
Sponsors:
Dr Nick O’Connor (Former Clinical Director, NSRMHS)
Sue Capel ( Former Service Director, NSRMHS)

Project team members:
Ricky Cavanagh, Briana Wynen, Lauren Ash, Andrew Nichols (Senior Nursing Staff RNSH)
Dr Tracey Fay, Dr James Telfer ( Senior Psychiatrists)

Quality Advisor
David Archer

Evidence and guidelines:
• In NSW there were nearly 3700 episodes of seclusion in 2016–17.
• RNSH Mental Health Inpatient Unit, 28 episodes of seclusion have been recorded in 2016–17.
• Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities (Dr Murray Wright, Chief Psychiatrist 2017) produced 19 recommendations.
• The NSW Government has made a major commitment to preventing the use of seclusion and restraint in NSW Health facilities.

Journey so far:
- Project team discussions with representatives of MDT
- Risk assessment tool modified to adopt the ward environment
- Risk-related clinical MDT management pathways developed
- Acute behaviour disturbance medical response developed
- Training to front line staff and junior doctors completed
- All patients admitted to HDU have BVC - Evaluated
- Effects on reducing the number of seclusion episodes - TBE

Results:

Seclusion Episodes
(No of seclusions in the month)

Seclusion Frequency
(No of consumers secluded / No of consumers admitted)

Overall Outcome of Project:
• All nurses in the ward have been trained to use the BVC
• Audit in November 2018, 74% of the patients admitted had BVC recorded.
• The seclusion episodes went down to zero on the month when project was started.
• The holiday period has affected the focus.
• The results so far have not seen a dramatic reduction. Better results are expected in the long term.

Plans to sustain change
Similar project with modified implementation strategy will be introduced in another unit.
New leadership needs to be identified to continue support the project.

Plans to spread/share change
Overall results will be reported once the one year period is completed.
TiToC (Timely inpatient care co-ordination and transfer of care): Has time run out?

Aim Statement:
By February 2020, St Vincent’s Hospital (SVH), Sydney will see a 10% decrease in the relative stay index and a 2% decrease in ALOS for acute patients as per published health roundtable data. This will be achieved by re-imaging the current TiToC Rounds.

Background:
At St Vincent's Hospital, TiToC (TT) rounds are held weekly, reviewing the cases of all patients who have been in hospital 5 days or longer. It is held to assess the need for a ‘difficult discharge’. It is an initiative designed to facilitate the transfer of care to hospital discharge. The TiToC rapid-fire discharge rounds are perceived by junior staff as time consuming and that questions asked are beyond their scope.

The culture of the rounds is negative, and participants reluctantly attend. No data is collected, or documentation is recorded for this initiative. This project aims to improve patient flow by achieving our SMART goal, while instilling positivity and enhancing team morale when looking at discharge planning.

Team members
Sponsor(s)
Mark Zacks
AProf Steven Faux
Project Team
RMO’s: Liz Dresco, Claudia Hurwitz, Gesta Baale
Patrol Fluid: Niki Zahra
Med Health: Michele Gilat, Naomi Tasawar, Ellie Thorne
Nursing: Lucy Rae
Discharge Co-ordinator: Phil Worthing, Katherine Paullette

Link to National Standard
Comprehensive Care Standard
- Clinical governance and quality improvement to support comprehensive care
- Developing the comprehensive care plan
- Delivering comprehensive care
- Minimising patient harm

Results & Outcome measures
Review of the literature identified the following factors as potential barriers to hospital discharge (New et al. 2013):

- Clinical Patient Flow Roundouts
- Change Ideas

Our PDSA cycles were trialled between Nov 2018-Jan 2019 on a single ward (735) - chosen for its enthusiasm for the project, and being the base ward of 2 selling party members. Each week different change ideas were integrated into the rounds and in January a second ward (7k) was added for a one-month full trial of our new model.

8 of the 10 Change Ideas have been implemented through the trial period using PDSA cycles and will continue to be used in the new model launch in March 2019. This includes a name change to ‘Clinical Patient Flow Roundouts’.

Discussion
Discharge planning and patient flow is multi-faceted and complex, therefore one tool will not be able to conceive define and manage this integral part of hospital care.

However we took a tool that was faling with the aim of not only looking for statistical improvement and bed days saved, but investing in grass-roots education and developing the discharge planning skills of the hospital community.

As a discipline, Rehabilitation Medicine sees many complex cases and has particular expertise in discharge planning, community transition and reintegration. Hence, rehabilitation/physicians are well suited to advise on complex discharge planning, and have a keen interest in maximizing patients outcomes and their ability to live in the community with independence. However, I also believe it is the role of everyone within a hospital to plan for discharge from day 1.

There are certain known characteristics and demographics identified in the literature that can impede and challenge a team trying to facilitate a return to the community. Early recognition and addressing of these factors is critical to ensure skills and resources are directed to assist those most in need.

This project has shown that by finding enthusiastic and motivated team members – our CPFR champions – with ten change ideas it was possible to achieve and implement 8 of these. It is hoped these ward level clinical representatives will foster a new culture surrounding patient flow by being a recognisable member of the ward team, as opposed to the traditional hierarchical concept that discharges and/or admissions are managed by executive or other non-clinical staff.

Meetings typically do not excite clinicians at the forefront of healthcare; hence we needed to change the ethos and atmosphere within meetings so participants felt they were a useful clinical tool and an environment where ideas could and would be shared. Anecdotal feedback from across the hierarchy of RMOs to Stream managers is already indicating that this has been achieved.

While final outcomes analyses of the 2020 roundtable data are yet to be undertaken, changes made to date appear to be sustainable and have made a tangible positive impact compared to the old TiToC model. Over the next year, formalisation of the model will be completed, and we hope this initiative will help meet our hospital KPIs whilst nurturing and developing skills in the workforce.

Overall Outcome of Project:
We have liaised with the hospital DON, Operations Managers, and RMO Managers amongst others to discuss and appraise our working party recommendations. All proposed changes were taken to different user groups and managers.

80% of change ideas have already been implemented either permanently or in the trial model that was rolled-out in November 2018.

Stretch goal is a future goal and success is still to be formally measured.

March 6th will see our new model launched hospital-wide.

We’re hoping these changes will not only reach our SMART goal, but educate and allow our hospital to become experts in timely and safe discharge planning.

Literature review


Change Ideas in PDSA cycles
Ease of documentation of recommendations

Plans to sustain change
Standardisation: Each ward’s CPFR will be asked to observe another CPFR each 6 months to maintain their ideas and enthusiasm. The Care Co-ordinators will report directly to the DON, as well as an annual review with the CPFR team. Measurement: A further consumer survey will be conducted in February 2020.

Plans to spread /share change
By definition, as a hospital-wide project our model will be used widely at a local level, with potential to be spread across other SVH sites or state-wide.

It has been submitted to the ACT Innovation Exchange
The original ‘TiToC’ model was entered into the SVH Quality Awards. Once we have data, consideration will be given to re-submission as an update and depending on our outcomes further publication of the results.

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March 6th will see our new model launched hospital-wide. We’re hoping these changes will not only reach our SMART goal, but educate and allow our hospital to become experts in timely and safe discharge planning.

Plans to spread /share change
By definition, as a hospital-wide project our model will be used widely at a local level, with potential to be spread across other SVH sites or state-wide.

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It has been submitted to the ACT Innovation Exchange
The original ‘TiToC’ model was entered into the SVH Quality Awards. Once we have data, consideration will be given to re-submission as an update and depending on our outcomes further publication of the results.
Aim Statement:
By November 30 2017, 50% people who are discharged from Dareton Community Mental Health and Drug & Alcohol (MHDA) team will have completed treatment.

Background to problem worth solving
2017 report identified that only 15.4% people who are discharged from Dareton Community MHDA team complete treatment to the satisfaction of the person and their case mgr.

Driver Diagram

The Problem:
Only 15% people who are discharged from Dareton MHDA Service complete treatment.

Smart Aim: By November 30 2017, 50% people discharged from Dareton MHDA Service will have completed treatment.

Outcomes Measure:
By when: Nov 30

Team members:
- Project Manager – B Heslop / K O'Neill
- HealthOne project in the region requires ongoing work on Gladstone

Link to National Standard or Strategic Imperative
- Standard 1 – Clinical Governance
- Standard 2 – Partnering with Consumers
- Standard 5 - Comprehensive Care

Rural MH Service Delivery Models: A literature review CRRMH (2014)

Discussion
- Increase % of patients seen at face to face contacts.
- Reduce % of patients who are discharged from Dareton Community Mental Health and Drug & Alcohol (MHDA) team.
- Improve % of patients who are discharged from Dareton Community MHDA team complete treatment.

Overall Outcome of Project:
We didn’t reach the stretch goal, but we improved
Building relationships in the region was really important

Plans to sustain change
1. HealthOne project in the region requires ongoing work on the model of care for this team and others in the region
2. Standardisation – policy documents published locally
3. Work with new T/2, when appointed

Plans to spread / share change
- Feedback to the project team members
- Enter into Far West LHD Quality Award 2019
- Presentation to Far West LHD and MHDA Executive
Improvement in access to rapid testing of Influenza in NSW

**Aim Statement:** By December 2017, 70% of people attending Emergency Departments at NSW hospitals for respiratory illnesses will have access to result for Influenza test within 4 hours.

**Background to problem worth solving**
Prior to 2016 Influenza testing was performed at 6 major hospitals. NSWHP transitioned to a multiplex platform delivering results within 4 hours. This had an impact on bed flow and decision making. NSW the time to result (TAT) was > 24 hours, impacting on bed flow and decision making. Required: Increased TAT for influenza test result would improve bed flow and clinical decision making and would provide equity of service within NSW.

**Team Members**
- **Executive Sponsor:** Professor Robert Lindeman
- **Clinical Lead:** Professor Raymond Chan, guide clinical decision making
- **Scientific Lead:** Dr Ian Carter, Principle scientist, performed correlations and also consolidated SOPs
- **Project Manager:** Ruth Yimsung
- **Quality Manager:** Susan Weston, Analytics: Alex Eigensletter, IT: Simon Winter, Communications: Nicole Tripney
- **MoH and Public Health Unit Liaison:** Dominic Dywer

**Driver Diagram**

**The Problem:**
Lack of equitable access to rapid diagnosis of Influenza across NSW

- **Primary Drivers**
  - Improved speed of diagnosis of influenza in NSW

- **Secondary Drivers**
  - SMART Aim: By December 2017, 70% of people attending Emergency Departments at NSW hospitals for respiratory illnesses will have access to result for influenza test within 4 hours

- **Change Ideas**
  - Evaluation of labs and LHD requirement for rapid influenza results
  - Decreased time to result for influenza results reporting
  - Implement new rapid testing platform
  - Improved service to LHDs clinicians
  - Consistent policy and procedures within NSWHP

- **Outcome Measure**
  - How much: improved accessibility
  - By when: 6-9 months

- **Outcome Measure**
  - How much: standardisation of procedure
  - By when: current FY

**Team Members**
- Project Sponsor: Robert Lindeman
- Project Officer: Ruth Yimsung
- Quality Officer: Sheena Adamson
- IT: Business Analytics: Dr. Alex Eigensletter
- Project Manager: Ian Carter, Principle scientist, performed correlations and also consolidated SOPs
- MoH: Professor Robert Lindeman

**Results**

**High**
- **Weekly Influenza cases**
- **Weekly Influenza deaths**

**High**
- **Weekly Influenza cases**
- **Weekly Influenza deaths**

**High**
- **Weekly Influenza cases**
- **Weekly Influenza deaths**

**High**
- **Weekly Influenza cases**
- **Weekly Influenza deaths**

**High**
- **Weekly Influenza cases**
- **Weekly Influenza deaths**

**Overall Outcomes of Project:**
1. Decreased time to result for influenza testing across NSW
2. Increased equity of service

**Cost saving:** potential savings with decreased Length of Stay reported in some LHD emergency departments.

**Plans to sustain change**
1. Standardisation of documentation completed
2. Standardisation of instrumentation completed
3. Training ongoing and required yearly
4. NATA accreditation achieved 2018
5. Testing is utilised differently across various sites

**Publications:**
1. Impact of rapid molecular diagnostic testing of respiratory viruses on outcomes of adults hospitalised with respiratory illness: A multicentre quasi-experimental study. J Clin Microbiology
Why weren’t we told?  
– Implementation of a Pre-conception Genetic carrier screening program

Dr Sondhya Ghedia Clinical Geneticist RNSH  
Email sondhya.ghedia@health.nsw.gov.au  
ECLP Cohort 20

- We are all carriers of at least one lethal genetic condition
- 1 in 20 people in Australia are carriers for either cystic fibrosis, spinal muscular atrophy or Fragile X syndrome
- In July 2018 the Royal Australian College of Obstetricians and Gynaecologists changed its position statement on genetic carrier screening to advise that “Information on carrier screening for the more common genetic conditions that affect children (e.g. cystic fibrosis, spinal muscular atrophy, fragile X syndrome) should be offered to all women planning a pregnancy or in the first trimester of pregnancy”.

**Problem:**  
Genetic carrier screening is not routinely offered to patients of reproductive age attending the genetic clinic.

**SMART Aim:**  
Patients attending the genetic clinic who are of reproductive age and planning a family, or in early pregnancy (<12 weeks) will be offered genetic carrier screening.  
How much: 100%
When: by December 2018

**Priority change ideas:**  
Develop a consensus screening protocol  
Who: all staff met to brainstorm ideas
Send patients information on carrier screening  
Who: admin staff
When: at time of sending clinic appointment details
Commence discussions on carrier screening  
Who: clinical staff
When: in clinic appointment
Whom: All patients of reproductive age planning a pregnancy or in first trimester of pregnancy.

**Results**

Patient response to the project:
- Were you aware of carrier testing before coming to our service?  
  Disagree (7/9)  
  No (7/9)
- Did you read the information brochure?  
  Yes (8/9)  
  Disagree (7/7)
- It was appropriate that carrier screening was discussed in the appointment.  
  Strongly agree/agree (7/9)  
  Disagree (4/7)
- The discussion made the appointment too long.  
  Disagree (7/7)  
  There was too much information given in the appointment.
- The discussion made me anxious.  
  Disagree (7/7)  
  Strongly agree/agree (7/9)

Project Outcome:
- Overall, 40% of eligible patients were offered carrier screening.
- Response rate for staff surveys was only 40%.
- Patient feedback was generally positive but again, response rate from the patient survey was low.

Lessons learned:
- We succeeded in raising awareness of carrier screening amongst our patients. Many patients indicated that they planned to discuss carrier screening with their friends/family.
- We succeeded in developing a screening protocol and process that was user friendly and that could be used in a busy genetic clinic.
- The project leader is integral in engaging staff to maintain change.

Acknowledgements:
- Dept of Clinical Genetics RNSH
- Patients of the Genetic Clinic
- CEC

References:
2. RANZCOG Statement on “Prenatal screening and diagnosis of chromosomal and genetic abnormalities in the fetus in pregnancy.” C-Obs 59 August 2018.

Moving forward:
Ultimately, carrier screening will be more effective if implemented by primary care physicians.
Clinical genetic professionals can assist in providing expert advice and helping to develop processes and resources for GP’s etc.
Aim Statement: By December 2018, to reduce the number of mental health ETP breaches at The Sutherland Hospital due to “medical care requirements” to zero.

Background to problem worth solving: NSW Health has an ETP target that 81% of patients who present to the Emergency Department will, within 4 hours, be discharged, transferred or admitted to an inpatient hospital bed. Overcrowding and access block in EDs (Emergency Departments) are identified as being associated with adverse patient outcomes. The Sutherland Hospital, has an ETP of around 77%. Delays in “Medical Clearance” are one of the biggest causes of mental health ETP breaches at The Sutherland Hospital.

Team members:
- Sponsor/s (Guidance Team)
  - Evelyn Chandler, Director Mental Health Service, Sutherland and St George Hospitals
- Project Team
  - Sophie Kavanagh – Clinical Director, TSH Mental Health
  - Oliver Barrett – Mental Health Lead, TSH Emergency Department
  - Danielle Coppleson – Access and Service Integration Manager, District Mental Health
  - Sharon Carey – Operations Manager, TSH Mental Health
  - Julie Durey – Inpatient Services Manager, TSH Mental Health
  - Peter Griffiths – Team Leader, Acute Care Team, TSH Mental Health
  - Leanne Horvat – NUM, TSH Emergency Department
  - Stephanie Stewart – Patient Flow, TSH and St George Mental Health

Link to National Standard
- Clinical governance
  - Patient Safety and Quality: Measurement and Quality Improvement, Risk Management

Literature review
- Australasian College for Emergency Medicine. The long wait: An analysis of mental health presentations to Australian emergency departments. ACEM: Melbourne, 2018
- Australasian College for Emergency Medicine, Waiting times in emergency departments for people presenting with acute mental and behavioural health issues. 2008, ACEM: Melbourne

Overall Outcome of Project: ETP Mental Health breaches due to medical care requirements seemed to be reducing until an unprecedented surge of ED presentations in December 2018.

Who is involved?
- Sponsor
- Project Team

Drivers for change
- Culture change is hard. People like the concept of “medical clearance” – it implies transfer of responsibility for risk.
- There are almost no incentives for services who are currently using the ED, despite alternatives, to stop doing so.

Link to National Standard
- Clinical governance
  - Patient Safety and Quality: Measurement and Quality Improvement, Risk Management

Approach
- Plan
  - Rapid Medical Assessment Test

Methodology
- Rapid Medical Assessment Test
- Plan
  - Rapid Medical Assessment Test

Resources:
- National ETP Breaches
- NSW Ministry of Health
- Mental Health for Emergency Departments – A Reference Guide
- Australasian College for Emergency Medicine
- Waiting times in emergency departments for people presenting with acute mental and behavioural health issues
- Australasian College for Emergency Medicine
- The long wait: An analysis of mental health presentations to Australian emergency departments
- Australasian College for Emergency Medicine
- Australasian College for Emergency Medicine

Plans to sustain change
- In ED admissions
  - MH ED breaches
  - # Direct MH admissions compared to ED admissions

Plans to spread / share change
- Present at a RANZCP Conference 2020
- Published in Psychiatry Journal
- Presented at a RANZCP Conference 2020
- Published in Psychiatry Journal
- Present at a RANZCP Conference 2020

Results
- Outcome measures
  - Mental Health ETP Breaches due to mental care requirements as % of total mental health presentations

Discussion
- Our remaining Medical Care breaches are almost completely attributed to sedation/intoxication and people with complex medical issues who do not meet current threshold for medical admission.
- A pathway out of ED for patients with short term but complex needs is the main road block now causing breaches. Culture change is hard. People like the concept of “medical clearance” – it implies transfer of responsibility for risk. There are almost no incentives for services who are currently using the ED, despite alternatives, to stop doing so.
Improving Monitoring of Complex Psychiatric Medications in Custody

Dr Sunny Wade  Consultant Forensic Psychiatrist  Sunny.Wade@justicehealth.nsw.gov.au  ECLP Cohort 20

Aim Statement: Within six months, 100% of patients taking complex psychiatric medications (clozapine and lithium) will remain safely treated with no serious adverse outcomes

Background to problem worth solving

There are high rates of mental illness in custody, including at the Area 2 Clinic at Long Bay Correctional Centre. Prison is a unique and challenging environment for healthcare. Clozapine and lithium can be very effective psychiatric treatments but require close monitoring. Side effects can be severe and potentially fatal. Successful treatment improves health and justice outcomes (reduced rearrest, reduced hospitalisations, improved safety to self and others). Patients want to remain on these medications if safe to do so.

Project Team

- Ms Michelle Eason (Director Organisational Development)
- Dr Sunny Wade (Team Leader)
- Dr Stephen Hampton (GP)
- Ms Marie Dudley (NUM)
- Mental Health Nurses
- Primary Health Nurses
- Pharmacists
- Admin Officers
- Mr S (consumer)

Team members

Sponsor
- Ms Michelle Eason (Director Organisational Development)

Project Team

- Dr Sunny Wade (Team Leader)
- Dr Stephen Hampton (GP)
- Ms Marie Dudley (NUM)
- Mental Health Nurses
- Primary Health Nurses
- Pharmacists
- Admin Officers
- Mr S (consumer)

Link to National Standards

- Standard 1 - Clinical Governance
- Standard 4 - Medication Safety
- Standard 9 - Comprehensive Care

Literature review


Outcomes measures:

- No clinic cancellations, or reduction of clinical time available due to the project.
- Ongoing data collection and monitoring
- Consider expansion to other complex medications and/or clinical cases

Plans to spread / share change:

- Submit to ACI Innovation Exchange
- Present at Justice Health Academic Program and other conferences
- Liaise with other Network projects in relation to metabolic monitoring and prescribing

Improving monitoring of complex psychiatric medications in custody

Drivers Diagram

Primary Drivers

- Systems
  - Process Measure: Review with pharmacy to streamline pathology testing
  - Process Measure: Review with pharmacy to streamline pathology testing

Secondary Drivers

- Team dynamics
  - Process Measure: Complex care multifunctional meeting
- Balancing Measures
  - High-flux load in prison, not considered at a priority

Team knowledge

- Process Measure: Staff education on psychotropic illness and medications

Patient factors

- Reduced patient knowledge
- Reduced seeking of services
- Disenchantment in custodial setting

Results

Outcome Measures

- Following the six month intervention period, monitoring of clozapine and lithium improved to best practice standards.
- 100% of patients had a medication level and ECG, saw a Psychiatrist, and were discussed at a multidisciplinary complex care meeting.
- The majority of patients were able to remain safely on medications (7/8). There were stable rates of lithium toxicity (1/8) and no serious heart problems (0/8).
- Additional benefits of the project included staff reports of improved communication and handover, and better understanding and confidence in managing physical health needs of psychiatric patients.

Results continued

- Process measures

Note: given the relatively low number of patients involved (8), the outcome and process measures were combined into one graph.

Balancing measures

There were no clinic cancellations or reduction of clinical time available due to the project.

Discussion

The key outcome of this project was that the small but complex group of patients treated with clozapine and lithium received best practice monitoring. Interestingly, these positive results occurred despite additional challenges, including unexpected transfers of patients between custodial areas, and changes in staffing. A low rate of serious adverse outcomes remained present. This suggests that despite improved monitoring, the needs of this patient group remains high. Future goals include keeping adverse outcomes as low as possible while continuing best practice monitoring and individualised care.

Change concept 1 - PDSA Cycle

<table>
<thead>
<tr>
<th>Change concept</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PDSA Cycle</strong></td>
<td>For improving monitoring of complex psychiatric medications in custody</td>
</tr>
<tr>
<td><strong>Change concept 1</strong></td>
<td>PDSA Cycle</td>
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</tbody>
</table>

Change concept 2 - PDSA Cycle

<table>
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<tr>
<th>Change concept</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>PDSA Cycle</strong></td>
<td>For improving monitoring of complex psychiatric medications in custody</td>
</tr>
<tr>
<td><strong>Change concept 2</strong></td>
<td>PDSA Cycle</td>
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</table>

Change concept 3 - PDSA Cycle

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<tr>
<th>Change concept</th>
<th>Description</th>
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</thead>
<tbody>
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<td><strong>PDSA Cycle</strong></td>
<td>For improving monitoring of complex psychiatric medications in custody</td>
</tr>
<tr>
<td><strong>Change concept 3</strong></td>
<td>PDSA Cycle</td>
</tr>
</tbody>
</table>

Overall Outcome of Project:

- Patients receiving complex psychiatric medications in custody received improved monitoring, and the stretch goal of 100% compliance with guidelines was reached.
- Some additional goals of reduced serious adverse outcomes were achieved.
- Staff reported improved communication, interest and confidence in caring for patients with psychiatric illness.
- Patients found the safe continuation of clozapine and lithium, where possible, highly valuable to their ongoing recovery.

Plans to sustain change:

- Continue complex care meetings in consultation with clinical staff.
- Ongoing data collection and monitoring
- Consider expansion to other complex medications and/or clinical cases

Plans to spread / share change:

- Submit to ACI Innovation Exchange
- Present at Justice Health Academic Program and other conferences
- Liaise with other Network projects in relation to metabolic monitoring and prescribing
Improving the availability of phenotyped red cells for transfusion

Tanya Powley
National Red Cell Reference Manager
Australian Red Cross Blood Service
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(07) 38389351

AIM STATEMENT
Within 6 months the Blood Service will increase filled phenotyped red cell orders to 88%.

- The Blood Service regularly phenotypes donors to maintain an inventory of antigen negative red cells to the more commonly found and clinically important antibodies.
- This inventory is used to support the transfusion needs of patients that have developed clinically significant red cell antibodies.
- The inability to provide antigen negative blood for these patients will impact clinical outcome either through delay or inability to transfuse the patient.
- It is critical that the Blood Service holds sufficient inventory with the appropriate phenotypes to support clinical demand.
- In the majority of cases clinically appropriate blood group substitutions were available which ensured that the patient received safe and appropriate treatment.
- Since August 2017 between 85.3 and 87.9% of phenotype orders have been filled as requested by the hospital

GATHERING DATA: ROOT CAUSE ANALYSIS
Analysis of the process and reasons for failure to deliver exactly what the customer required demonstrated that the root cause was insufficient inventory particularly for specific ABO and Rh blood groups. Four change ideas were selected for further investigation.

CHANGE IDEAS
<table>
<thead>
<tr>
<th>Change Idea</th>
<th>Priority</th>
<th>Name of Change Idea to be tested in a PDSA Cycle</th>
<th>Method of measuring change on improvement</th>
<th>Predicted to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retrospective testing of donors missing extended Rh &amp; K typing</td>
<td>High</td>
<td>Cycle 1</td>
<td>Retrospective testing of donors missing extended Rh &amp; K typing</td>
<td>Improve inventory to support requests for blood requiring Rh and K matching only.</td>
</tr>
<tr>
<td>Cycle 2</td>
<td>Increased number of donors given a specific antigen blood group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cycle 3</td>
<td>Increased number of phenotype orders filled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cycle 4</td>
<td>Increased number of phenotype orders filled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marketing campaign</td>
<td>Medium</td>
<td>Cycle 5</td>
<td>Increased number of phenotype orders filled</td>
<td></td>
</tr>
</tbody>
</table>

RESULTS
Run Chart of Percentage of Phenotype Orders Filled

OUTCOME
This change appears to have not made a significant impact on DIFOT. Although this must be balanced against the increased demand observed since April 2018.

WHAT’S NEXT?
The retrospective extended Rh & K testing will continue until all donors have been tested. In February 2019 automated phenotyping will move from planning (Plan) to implementation (Do). Testing will be transferred to an automated testing platform which will enable a significant increase in testing capacity. This will be monitored (Study) to observe the impact on provision of phenotyped red cells. Adjustments to the testing numbers may be required to ensure we meet or exceed our target.
Early Treatment of Patients Needing Simple Surgical Extractions

Dr Trupta Desai
Head of Department and Clinical Manager Community Oral Health Clinics, SLHD

ECLP Cohort 20

This quality improvement project is aligned with National Safety and Quality Health Service Standards, Second Edition

Standard 1 Clinical Governance
Standard 2 Partnering with Consumers
Standard 3 Preventing and Controlling Communicable-Associated Infections
Standard 4 Patient-Right
Standard 6 Communicating for Safety

Change Concept 1 via a PDSA Cycle - Realization of second surgical motor to COHC improved clinical time and chair availability

4. ISDN data was obtained from ISDN data. The second surgical motor was installed in July 2017 and was completed per month in 2018. An increase in number of surgical extractions were compared to previous year 2017

Change Concept 2 via a PDSA Cycle - Assessment of all referrals from the general dentist to Oral Surgery and reallocation to COHC decreased unnecessary referrals

1. All referrals from Dental Officers and HOD provided monitoring and support of ISDN data. April 2017 to March 2018 were recorded in ISDN to check appropriate referral. If referrals for management in COHC were re-assessed by SDO and subsequently referred to Oral Surgery Specialist.

Change Concept 4 via a PDSA Cycle - Mentoring and support of Dental Assistants by providing additional training in surgical technique, surgical judgment and providing regular feedback and support by providing regular support of ISDN data

1. SDO manager and Senior Dental Assistants identified ISDN data. Referrals for management in COHC were re-assessed by SDO and subsequently referred to Oral Surgery Specialist.

Overall Outcome of Project

In April and June 2018 we reached our stretch goal of 90%.

Change Concept 4 via a PDSA Cycle - Mentoring and support of Dental Assistants by providing additional training in surgical technique, surgical judgment and providing regular feedback and support

1. All referrals from Dental Officers and HOD provided monitoring and support of ISDN data. April 2017 to March 2018 were recorded in ISDN to check appropriate referral. If referrals for management in COHC were re-assessed by SDO and subsequently referred to Oral Surgery Specialist.

Change Concept 3 via a PDSA Cycle - Mentoring and Support of Dental Officers and providing regular feedback increased scope of practice and surgical skills

4. Increased number of simple surgical extractions per hour

Change Concept 5 via a PDSA Cycle - Monitoring of patient expectations and involving patients in their care improved the outcome of treatment

• Regular feedback provided improved management of patients in COHC and decrease unnecessary referrals.

Cost Saving in Dollars

This results were compared by DWAUs produced due to surgical activity per financial year showed:

June 2017 to June 2018 $71,090

June 2016 to June 2017 $62,372

Overall Outcome of Project

In April and June 2018 we reached our stretch goal of 90%.
Geriatrics Referrals Improvement Project (GRIP)

**Aim Statement:**
Within 12 months, all the referrals to Aged Care meet the minimal referral information requirements

**Background to problem worth solving**
Semi-formalised process for referral to the aged care service. Inadequate knowledge of the referrer in terms of appropriateness of the referral, the referral process, requirements of information, the capacity and the role of the aged care unit. This has resulted in referrals being sent to multiple channels, inadequate information received, increased time and effort to gather the correct information and ultimately led to a delay in the decision-making process and increased the medicolegal risk faced by the organisation.

**Team members**
- Sponsor/Leadership Team
  - Dr Stephen Hampton (Executive Medical Director)
  - Dr Welke Sim (Geriatrician, Long Bay Hospital)
  - Linda Malusa (Nurse Practitioner, State-wide, Aged Care)
  - Cindy Stoupas (Clinical Nurse Consultant, Specialist Mental Health Service for Older People, Long Bay Hospital)
  - Elizabeth Twomey (Nurse Unit Manager, Aged Care & Rehabilitation Unit, Long Bay Hospital)
  - Dr Andrew Watt (Psychiatrist, Long Bay Hospital)

**Results: Outcome Measures**

**Overall Outcome of Project:**
- We were able to achieve our stretch goal, despite change of staff half way through the project.
- Current study only targeted several referral sources and overall number of referrals was small
- We were able to pick the two most important change ideas to implement
- The challenge in the future is to maintain the gain.

**Plans to sustain change**
- Regular information sessions for staffs
- Continue to collect data on a regular basis and perform yearly audits
- Recruit more staff – Nurse Practitioner
- Obtain feedback from staffs

**Plans to spread & share change**
- Submitted to the AGI Innovation Exchange