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The CEC Clinical Leadership Program has no association with the Royal College of Nursing, United Kingdom (RCN, UK) Clinical Leadership Programme, represented in Australia by the Royal Adelaide Hospital.
The Clinical Excellence Commission

The Clinical Excellence Commission (CEC) was established in 2004 to promote and support improved clinical care, safety and quality across the NSW Health System.

The CEC’s mission is to build confidence in healthcare in NSW by making it demonstrably better and safer for patients and a more rewarding workplace. Strategies for sustainable patient safety and system improvement are dependent on strong clinical leadership capabilities. The belief in the power of clinical leadership is an essential component of CEC’s commitment to improving patient safety and clinical quality in our healthcare system.

‘Clinical Leadership’ occurs at all levels of patient care and refers to the process of leading a set of activities that improve the delivery of safe clinical care, and the set of attributes required to lead a team, unit, stream or cluster.

In this booklet you will find a summary of projects undertaken by participants in the Clinical Leadership Program. Over 100 different projects have been undertaken by the 2007 cohort alone. The results of many of these projects clearly demonstrate a strong commitment to healthcare improvement through effective clinical leadership.

I am pleased to commend this booklet and encourage its use as a tool for continuing dialogue towards healthcare improvement and potential applications for change within the Area Health Services.

Professor Clifford Hughes AO
Clinical Professor
Chief Executive Officer
Clinical Excellence Commission
Clinical Leadership Program

The launch of the Clinical Leadership Program (CLP) in 2006 marked a significant development for the Clinical Excellence Commission (CEC) and the NSW health system.

The aim of the program is to build a cohort of effective clinical leaders who progressively become the ‘critical mass’ needed for patient-centred system change.

The CLP is offered in two different modes: Statewide and Modular. The Statewide program is a multidisciplinary program, targeting clinicians at a middle management level. It is delivered by local Area Facilitators within an area health service. The Modular Program targets senior clinician managers and this program is delivered as five intensive modules in Sydney. Participants attend modules which focus on the personal and professional attributes of effective leaders.

Both programs require the completion of a clinical service challenge which provides the opportunity for participants to apply the skills and learning from the program. It also enables the strengthening of links between effective governance, core leadership competencies, a culture of safety and quality and continuous improvement.

Clinical Practice Improvement methodology is a key learning area of the program as it provides a model upon which the clinical service challenge can be addressed. This methodology requires the participants to identify a problem in their clinical area which directly impacts on patient care.

Publication of this booklet has a twofold purpose. It showcases some of the demonstrated outcomes of the clinical projects and encourages the sharing and application of the projects more broadly throughout the health system.
There is a listing of all projects undertaken by the 2007 cohort of both the statewide and modular CLP participants in this booklet. All participants are to be congratulated on the scope of issues addressed. The projects chosen to be summarised in this booklet were selected due to the quality of the participants’ submission to the CEC.

The CEC acknowledges with thanks the contribution and cooperation of the participants, their facilitators, managers, the Clinical Governance, Clinical Redesign Units within AHS and the considerable expertise provided by an extensive external faculty of trainers.

Ms Bernie Harrison  
Director, Organisation Development & Education  
Clinical Excellence Commission

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

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Overview of CPI methodology
The Modular program
Thirty one senior clinician managers successfully completed the Modular program in 2007.

A clinical service challenge was completed by each participant as part of the program. Many used clinical practice improvement methodology. All participants were required to present their project as part of a final assessment day hosted by the CEC.

The Statewide program
164 people successfully completed the program in 2007.

The Statewide program is delivered at an Area Health Service level by local facilitators. As a part of the program participants undertake a Clinical Improvement Project and present this to Area management and sponsors at the end of the program.

2007 Modular Clinical Leadership Program
Participants standing left to right: Michael Datyner, Chris Milross, Mary Mitchelhill, Neil Berry, Alan Tankel, Alan Forrester, Randall Greenberg, Bruce French, Geoffrey Ramin, John Erikson, Louis Christie, Michael McGlynn, Paul Craven, Michael Boyle, Jonny Taitz, John Christie, Steven Allnut, Steven Katz, Warwick Benson, Paul Summers, Barry Elison. Seated left to right: Anne Greer, Liz Mitchell, Jan McCaig, Liz Mullins, Cliff Hughes, Bernie Harrison, Fran Gearon, Lyn Currie, Kate Needham.

Hunter New England Statewide graduation
Left to right: Helen Scott, Maria Biancotti, Jenny Haxton, Alison Fielder, Bernie Harrison (CEC), Sandy Ryan, Jenelle Langham (Lead facilitator), Lisa McGavern, Jeff Hescott, Kane Wyborn (Local Facilitator)
Developmental Program for Babies and Toddlers with Achondroplasia

Ms Verity Pacey
Senior Physiotherapist, The Children’s Hospital
Westmead
Western Sydney Area Health Service

Mission:
To develop and implement a systematic program to meet the ongoing developmental needs of all children with achondroplasia aged 0-3 years (attending the CHW Connective Tissue Dysplasia Clinic) within the next six months.

Summary of the Project:
The Connective Tissue Dysplasia (CTD) Clinic at The Children’s Hospital at Westmead (CHW) provides diagnosis, assessment and rehabilitation management for patients born with disorders involving defects in the connective tissues such as bones, ligaments, tendons and skin.

One of the disorders managed within the CTD clinic is achondroplasia — a skeletal dysplasia resulting in short stature. All patients with achondroplasia are classified as having a physical disability and are therefore expected to have a delay in their gross motor and fine motor skills. Achondroplasia is not associated with a cognitive delay. However, much of the early rehabilitation management
of these patients focuses on education for the parents in preventing long term damage to the child’s spine. Retrospective data and recent research involving the CTD clinic’s cohort has identified an increased developmental delay in this patient group, with few families accessing all required therapy. In addition the current ‘best practice’ health supervision guidelines are not being followed in a co-ordinated or standardised manner.

A project team was formed which included representatives for all key stakeholders such as CHW CTD clinic professionals, a paediatrician, a community therapist, and a parent representative. The team held a brainstorming session incorporating most members of the project team, which identified areas for improvement.

Following two multi-voting rounds, the main areas to be focused on within the project were identified. Interventions undertaken within the project to date have included the formation of therapy ‘guidelines’ for local therapists, parent information sheets, a roadmap for new parents, the provision of speech therapy assessments for all children at 2 years, and new developmental assessment templates.

**Outcomes of the Project:**

**Developmental assessment:** A key measure for this project is the percentage of achondroplasia patients aged 0-3 years that have a documented global developmental assessment, which identifies individual patient needs, performed within the last six months. A baseline measure of this was taken at the initiation of the Diagnostic Phase (July 2007) to allow measurement of improvement throughout the project course. **Goal:** 80% of patients to have undergone a developmental assessment within four months, stretching to 100% within six months. **Result:** Within three months 65% of patients have undergone a developmental assessment.

**Individualised plan:** The percentage of achondroplasia patients aged 0-3 years with an individualised developmental program and plan of care implemented within four weeks of assessment. **Goal:** Within four months, 80% of patients will have with an individualised program and plan of care implemented within four weeks of assessment, stretching to 95% within six months. **Result:** Within three months, 88% of patients have had this implemented.

**Fixed kyphus:** The percentage of patients with a fixed thoracolumbar kyphosis on clinical examination at each CTD clinic appointment. This is being measured to ensure management of the developmental progress of patients is not at the expense of their preventive spinal care. **Goal:** No increase to occur. **Result:** Reduction has occurred so far.
End of Life Care Planning

Michael Daytner
Network Director, Aged and Chronic Care
Sydney West Area Health Service

Mission:
To provide a strategic approach and plan for the area-wide implementation of interventions designed to improve the care planning and management of patients at the end of life.

Summary of the Project:
The multi-disciplinary End of Life Expert Reference Group was asked to develop a strategic plan for Sydney West Area Health Service which addresses end of life care planning in both the acute hospital and the community settings. In the acute care setting, the plan addresses the co-ordination of staff roles, standardisation of processes, and understanding the wishes of patients. Improved transfer of information between acute care and residential aged care facilities was identified as a key requirement in fulfilling the plan.

The draft plan now in place identifies a need for clear governance structures to provide advice, guidance and monitoring of system processes for end of life care. A policy framework that supports care planning and management of patients at the end of life is also required. Standardisation of processes and improved access to services is needed.

Outcomes of the Project:
The project remains a work in progress and it is planned that the final draft of the strategic plan will be submitted to the Sydney West Area Health Service Executive and Chief Executive for endorsement. A plan to implement the strategy will form part of the final draft, as will strategies for sustaining improvement. The issues that are being addressed by the End of Life Expert Reference Group are relevant to all Area Health Services in NSW. The project has proved invaluable in shaping our plan and raising our awareness of the complexities of advance care planning and end of life care.
Falling and Malnourishment – the Occupational Therapy Link

Ms Rosie Kew
Manager Occupational Therapy, Lismore Base Hospital, North Coast Area Health Service

Mission:
To conduct malnutrition screening during Occupational Therapy assessment on 80% of the patients with fractured necks of femur in ward C6, Lismore Base Hospital, by 31 October 2007.

Summary of the Project:
This project was undertaken following media interest in the outcome of a study undertaken in 2006 at Prince of Wales Hospital in conjunction with the University of New South Wales, which found that up to 80% of elderly patients admitted to hospital were at risk of being, or were, malnourished. The Occupational Therapy (OT) team sought to address this. Occupational Therapists (OTs) are involved with patients’ ability to shop, access the community, prepare meals, and to eat those meals.

The team chose patients with fractured necks of femur (#NOF) to initiate the clinical change as this was a high risk group for malnourishment, and presented another physical manifestation of a fall (the fracture). An audit of #NOF admissions showed that none had been identified as malnourished by the current nutrition screening processes. This did not fit the clinical picture, clinical reasoning, or the literature. An inter-disciplinary approach with the dieticians assisted in identifying an appropriate screening tool, which the dieticians trained OTs to use. Using ‘Plan, Do, Study, Act’ cycles, implementation of the tool was trialled, and barriers were identified. A Pareto analysis was also conducted to establish priorities.

Outcomes of the Project:
The outcome from the Pareto process was to choose a more appropriate screening tool for this patient cohort, and to train OTs in its use.

Barriers to the success of the project were identified as:
- Staff culture and attitude in relation to malnutrition;
- No weighing of non-ambulant patients at any time during their admission (guesstimate of patient weight used for interventions);
- Attitudes towards trans-disciplinary practice;
- Staffing issues within OT; and
- Time to undertake screening for malnutrition.

Recommendations to overcome these barriers were:
- Presentation to the LBH Clinical Risk Committee, with recommendations;
- Purchase of bed weigh scale for use in
the Emergency Department;
• Improvement in documentation of patient weights;
• A weighing protocol established for non-ambulant patients, including elderly and trauma patients; and
• Ongoing audits to ensure compliance with weighing of patients and maintenance of documentation.

The processes to overcome barriers are being implemented with outcomes projected as:
• patients with #NOF will have full access to screening for malnourishment by the OTs;
• patients will then be referred appropriately on to the dieticians and rehabilitation occupational therapists for intervention.

In addition, an outcome already achieved is the interest shown in uptake of the assessment process by other allied health professions, especially with regard to falls prevention.

Strategies for sustaining improvement:
• Ongoing training for new staff;
• Rollout of screening to any patients that OTs believe may be malnourished or at risk of becoming so (identifying medical patients who may potentially present in future with #NOF);
• Further encourage the uptake in screening by other allied health professions; and
• Ensure the weighing of patients is occurring in all hospitals in NCAHS.

What services / areas could benefit from adopting the same or a similar project?
• Other OTs – community and acute based. The application in the community would be very beneficial as OTs go into people’s homes and it is easy to check people’s ability to prepare meals, shop and eat.
• Other allied health professionals.
• The development of this project is considered a great adjunct to falls prevention strategies.
Improving Physical Health for People with a Mental Illness

Ms Fiona Beston
A/Manager of Community Mental Health,
Coffs Harbour
North Coast Area Health Service

Mission:
By the end of November 2007 60% (n=198) of Case Managed Community Health clients will have had a nursing physical and will have been linked with a General Practitioner (current base line is 15%).

Summary of the Project:
Mental health clients in Coffs Harbour and surrounds have a low contact rate with general practitioners (GPs) for several reasons, including limited access to bulk billing and transport. People with a mental illness are at higher risk of co-morbidities such as diabetes, heart disease, and obesity. Medication side effects and sedentary lifestyles are the major contributors to the onset of such conditions.

Research indicates that better outcomes for physical health can be achieved by focusing on a holistic approach to health for people with mental illness. The project has so far completed one ‘Plan Do Study Act’ (PDSA) cycle with the main strategy being to physically assess all current community mental health clients in Coffs Harbour. This task was undertaken by a community mental health nurse. Results of the nursing physical assessments were recorded and copies were sent to the GP with a letter explaining the project and what we were trying to achieve. Staff of the community mental health team communicated the benefits of participating in the physical assessment with their clients.

Outcomes of the Project:
Between May and November 2007:
- 182 Community mental health clients were offered a nursing physical examination (55%).
- 155 were assessed, 27 refused.
- 106 identified that they had a GP.
- 55 out of the 76 people who were recorded, smoked tobacco.
- The Body Mass Index (BMI) average for women assessed was 28.5, and for men, 27.7, which demonstrated that the majority of mental health clients are in an unhealthy weight range.
- Even though the average blood pressure and blood sugar levels were in the normal range there were a number of clients in the high risk range, and there were a higher percentage of men than women in these categories.

All results and a letter explaining the project were sent to each client’s GP to encourage further physical assessment and monitoring. All clients were given written and verbal information on strategies for improving physical health, e.g., reducing risk of heart
The Mother-Baby Continuum

Ms Joanne Campbell
Clinical Nurse Educator – Special Care Nursery
Port Macquarie Base Hospital,
North Coast Area Health Service

Mission:
To achieve 100% of well mothers and babies having continuous contact following elective lower segment caesarean section at Port Macquarie Base Hospital by November, 2007.

Summary of the Project:
Mother-Baby Continuum: That there is continued contact between mother and baby, i.e., no separation.

Historically, healthy babies born via elective lower segment caesarean section were separated from their mothers for admission to Special Care Nursery (SCN) for four hours’ mandatory observation. This is no longer current practice yet the separation continues unaddressed. This project refers to a well mother and well baby.

Aims of the Project:
• To provide the opportunity of skin-to-skin contact between mother and baby immediately after assessment at delivery, in accordance with NSW Health Policy Directive (DOHD PD) 2007_024; 4.3.
• To initiate breastfeeding within the first hour of birth, in accordance with NSW Health Policy Directive (DOHD PD) 2007_024; 4.4.

Future plans include:
• Continuing with the nursing physical examination program – all community mental health clients will have a nursing physical once a year.
• Continuing to send information to GPs.
• Providing further education to mental health staff on the importance of physical health monitoring as part of a holistic approach to care.
• Conducting a second PDSA in 2008 involving contacting all the GPs who received a letter and results to ask them to participate in a brief questionnaire on physical health follow up.
• Developing strategies for implementing the program across NCAHS.
• To enable, not hinder, the mother-baby continuum while supporting the family unit, in accordance with NSW Health Policy Directive (DOHD PD) 2007_024; 4.5.

Outcomes of the Project:
During the trial period the goal of 100% of well mothers and babies having continuous contact following elective lower segment caesarean section was achieved. Data collection proved skin-to-skin contact in theatre maintained the baby’s temperature and enhanced the opportunity to bond between mother and baby. Skin-to-skin contact occurred on average between four and five minutes after birth. By not separating mother and baby, breastfeeding initiation fell from an average of between two and two-and-a-half hours (previously the time the mother returned to maternity from recovery) to between 40 and 50 minutes. Babies remained alert and they breastfed well. Parent data collection was overwhelmingly positive and supportive of the implementation of this practice change.

Funding was sought, and has been approved, to increase midwife hours to support the family with breastfeeding assistance during their time in recovery (from one-and-a-half to three hours). This funding will allow regular rostering of staff for Elective Caesarean Section lists and remove the haphazard occurrence of this support which was previously only permitted if the birthing suite was not busy and staff were able to respond.

Neonatal Transport in Hunter New England
- “Look beyond the crisis”

Dr Paul Craven
Neonatologist, John Hunter Children’s Hospital
Hunter New England Area Health Service

Problem:
John Hunter Children’s Hospital (JHCH) had a standalone acute neonatal retrieval service, which had been operating for 30 years. This service allowed sick babies in the Hunter region to have access to a mobile intensive care unit, if they were born or became sick somewhere other than a major metropolitan hospital that had its own intensive care facilities. Due to acute staff shortages the service had reduced in capacity and in 2004 only 6 acute retrievals were performed. In 2005 the service was reviewed and felt to be an important aspect of neonatal practice in the Hunter Region, building vital partnerships and offering excellent local support to smaller neonatal units in the Hunter New England and North Coast region of NSW.

Mission:
To deliver optimal advice, care and retrieval for all sick babies in our region within 18 months.

Summary of project:
A multi-disciplinary team was formed consisting of both providers and consumers
of the neonatal retrieval service. The team undertook a Task Safety Analysis using Failure Mode Effect Analysis methodology. The methodology is a proactive risk assessment looking for all potential risks, and identifying the likelihood of these risks occurring and then solutions to prevent them actually happening. The model is popular in industry, with numerous references in the mining industry, which enabled us to source local help with this model.

Overall, we identified 25 key task steps in the neonatal retrieval process, with 63 actual risks in these steps. All 63 risks had some degree of control already built into the service, however 54 identified risks still had residual risk and these were categorised by rating their likelihood of recurrence as being extreme, high, medium or low risk.

Examples of the identified risks include:

1. Inability to direct calls for help appropriately when they were made directly to the John Hunter Children’s Hospital Neonatal Intensive Care Unit. The risk here was that the person taking the call would not be able to find, or would not know who to find, provide advice or retrieve the baby. The control in place was that if no suitable staff member could be reached at JHCH they would call NSW NETS. The residual risk of this scenario is still being unable to find someone suitable at JHCH.

The risk solution was to develop a coordinated program through NETS NSW; issue instructions that mobile phones and pagers were to be carried by staff involved so they could be reached at all times; and develop and maintain a database of who was on call for retrievals at all times at the NETS base. This has resulted in a one number system for NSW for retrievals, and one phone call for the referring practitioners with conferencing facilities, support, advice and retrieval plans made immediately.

2. Giving stabilisation advice to local practitioners. The risk was that local practitioners did not have training in advanced neonatal practice. The control in place was offering centrally based educational facilities. The residual risk for many is the inability for rural clinicians to leave smaller centres, where they may be the sole practitioner. The risk solution was to create an outreach education working group to take education to rural settings in Hunter New England and the North Coast of NSW.
By using a likelihood severity matrix it became clear that the problems we targeted first were of high likelihood with maximum severity, and this allowed us to be strategic in our problem solving.

Following the Task Safety Analysis we undertook a SWOT analysis and plotted the history of the service to develop our mission statement, and identified three key areas we wished to focus on for the future. Problems could then be processed using Clinical Practice Improvement Methodology to identify causation of problems and hence develop effective solutions.

**Outcomes of the Project:**
Having identified 63 risks and 54 of these with residual risk we identified solutions for every residual risk. We now have 100% capacity to give advice regarding all sick newborns in Hunter New England (HNE). We have become recognised as an independent branch of NSW NETS, branded Hunter NETS.

We retrieve 75-100 sick newborns a year to or from JHH, which is approximately 75% of the total for the HNE region. We have expanded the neonatal intensive care unit from 29 to 41 beds, with 90% occupancy rates.

We have developed an extensive outreach education program offering education to all rural practitioners in the HNE/North Coast region of NSW, which has independent funding, and we have won both local and national recognition for our contribution towards education in NSW. To provide excellence in care during the retrieval process and to ensure a sustainable workforce we have trained three additional neonatal nurse practitioners and now have a team of five to help run the service.

To ensure the future development of the service we performed a SWOT analysis, and developed a mission statement and a business plan. The areas we are concentrating on are:

1. Independent funding for the service. In 2008 we took delivery of the Hunter NETS ambulance which is fully staffed and based at the NICU for immediate service at all times. This acquisition was externally funded.

2. To create a leadership role within the service. This is now on the NICU balanced score card as a priority for 2009.

3. To achieve a sustainable workforce. We have trained additional nurse practitioners to ensure a skilled and sustainable workforce. One of the key areas to target from our strategic business plan was to increase nursing staff in the service. A brainstorm revealed leadership and education were high priorities to address this key issue and hence we have had two training courses delivered for nursing staff to train to become active team members.
Pharmacist in Emergency Department

**Ms Margaret Hewetson**  
Director of Pharmacy Services,  
Lismore Base Hospital  
North Coast Area Health Service

**Mission:**  
To improve the quality of information on medicines at admission for patients over 65 years old and who are on more than five medicines.

**Summary of the Project:**  
It was identified as part of the Clinical Services Re-design Program that decreasing the length of stay for elderly patients with chronic illness was a priority. Pharmacy services were approached to assist with the process. A pharmacy graduate saw patients in ED who were over 65 and on five or more medicines to ensure their list of medicines was correct. To obtain accurate information about the patient’s medicines, the pharmacist talked to the patient and their carers and contacted the GP and community pharmacist.

**Outcomes of the Project:**  
Of the total of 176 patients seen by the pharmacy graduate, 56 patients had at least one medicine missing from their list. On average 2.5 medicines were missing from their list, including high risk medicines such as anticoagulants, medicines to treat cardiovascular complaints, antibiotics, painkillers and a range of complementary and alternative medicines. If these medicines had not been identified and added to the patients’ medication charts, their omissions would have complicated the diagnosis and treatment of the patients and may have lengthened the patients’ stays in hospital. Other interventions included adjustments of dose and drug, discontinuing medicines, organising a dosage aid and counselling patients about their medicines.

Potential SAC ratings were allocated to the interventions. Of the total of 176 patients who were seen, 54 interventions were potential SAC 2 and 17 were potential SAC 3. The remaining 105 patients did not have any medicines missing and did not require any intervention with respect to their medicines.
ED staff appreciated having an accurate list of medications at admission. In addition, by having a pharmacist in ED, they could get answers to questions about medicines and pharmacy issues very quickly. Ward doctors particularly supported having the list of medications at admission written on the drug chart as it made the job of writing discharge summaries much easier.

The NCAHS Drug and Therapeutics Committee have asked for a presentation of the results. NSW Health’s Performance Improvement Branch is also very interested in the topic of improving medication management and visited NCAHS, to discuss the project and to raise the issue with NSW Health.

Prevention of Major Joint Infection – Hip

Ms Debbie Spokes
Nursing Unit Manager
Hunter New England Area Health Service

Mission:
The aim of this project was to prevent post-operative hip joint infection at Armidale Rural Referral Hospital, and to reduce post-operative wound infection within a 12-month period to an acceptable level, i.e., in line with the International Standard of 2%.

Summary of the Project:
Through achievement of the stated aim, the project objective was to improve patient-focused best practice outcomes and quality of life after total hip replacement. The following strategies were implemented to achieve the aims, and their continuance will assist in sustaining improvement:

1. The introduction of the American Society of Anaesthetists’ (ASA) scoring system of pre-operative risk assessment in the pre-operative clinic to determine suitability of patients for joint replacement surgery.

   • The ASA score puts patients on a rising scale from 1 (being well) to 5 (being unwell). The score is determined by several factors which include BMI, age, anaesthetic/surgery duration, blood loss and post-operative stay duration. Scores

“The task of leadership is not to put greatness into people, but to elicit it, for the greatness is there already.”
John Buchan
usually increase with age and obesity. Since this system was introduced, only patients with an ASA score of 3 or less are selected for surgery. This effectively reduces the risk of post-operative wound infections in our joint replacement patients, as they are in a lower risk category for such developments by virtue of their overall pre-operative health.

- Evidence from an audit of three patients, who represented with post-operative joint infection before the introduction of the ASA scoring system, found the patients would have had ASA scores greater than 3, had the tool been used at the time of pre-operative assessment.

2. A guideline has been developed for surgical ward staff regarding how to prepare patients undergoing joint surgery for theatre.
- Patients have two pre-operative showers with triclosan one percent, one at home and one on admission, before surgery.
- There is a designated shower and ward for joint replacement patients only, and patients are admitted earlier to ensure all pre-operative care may be completed before surgery.
- There is an ongoing review of the joint surgery pathway with staff involvement and better compliance.
- The introduction of a new dressing that is more absorbent than the previously used dressing. It is called PolyMem dressing, and is used in the surgical ward and theatre. Staff have received instruction in its use and the importance of keeping the dressing dry and intact until discharge is emphasised.
- Surgical ward and theatre staff have been educated in the use of bellovac drains for autologous transfusions.

4. As a result of the review of post-operative joint infections, casts are removed prior to theatre unless contra-indicated (unstable fracture), due to the increased risk of infections they present in being removed in-situ. This strategy is more specific to general orthopaedics.
5. Ward rounds with surgeons accompanied by senior nursing staff and with allied health staff involvement were introduced.

6. Peer review by Tamworth CNC recommended that Orthopaedics offer support and assist with the establishment into practice of some of the above recommendations and changes.

**Outcomes of the Project:**

- Post-operative hip wound infections have been reduced, with only one identified since May 2007.

- Patient stays have been reduced, and patient care has been improved, which has also led to significant reductions in overall expenditure.

- Implementation of patient-focused strategies has led to improved patient outcomes through all phases of surgery.

- The project assisted in clearly establishing a link between co-morbidities and joint infections at Armidale hospital.

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Reducing surgical site infection in the paediatric neurosurgical patient

Dr Raymond Chaseling
Neurosurgeon, The Children’s Hospital Westmead
Western Sydney Area Health Service

**Mission:**

To reduce the incidence of surgical site infection in the paediatric patient admitted for insertion of VP shunts and EVDs from 7.5% to zero % within 12 months.

**Summary of the Project:**

Surgical Site infections (SSIs) are the second most common type of adverse event occurring in hospitalised patients.

This project, led by the Neurosurgical Department at The Children’s Hospital Westmead (CHW), was established in 2007, to reduce surgical site infections (SSI) in children admitted for insertion of ventriculoperitoneal (VP) shunts and insertion of external ventricular drains (EVDs).

The project team met with stakeholders to review and identify the current practice. A protocol was developed in conjunction with the stakeholders, following extensive evidence-based research. A review of the medical literature was performed to identify the evidence-to-practice gap. The protocol was designed using the concept of ‘bundle
of care’, where an individual component is known to reduce the risk of surgical site infections, but when all components of the protocol are followed in unison the risk of surgical site infection is further reduced. High risk babies were included in the study. Historical data of the shunt infection rate was known from KPIs and surgical indicators for 2006.

**Protocol:**
- Shunt “bundles” were placed in theatres.
- Staff were educated on ward, team and the key areas of NICU, PICU and Westmead NICU.
- Continuing education of staff coming and going, especially medical staff, was implemented.
- Project Officers were involved in checking theatre lists and admissions to include all patients.
- Compliance to the shunt protocol was measured monthly and the preliminary shunt infection rate was calculated comparing it with historical data.

**Outcomes of the Project:**
The information on the protocol checklist is entered into the database once the patient has been discharged, and results are measured using process measures and outcome measures.

To date, the incidence of surgical site infection has reduced significantly from 7.5% to 1.4%. In 2008, the rate of SSIs currently stands at zero %.

Any non-compliance to the protocol is measured and the information is collated. Since project commencement in March 2007, overall, compliance with the protocol has been over 85%.

Winner of the CEC Patient Safety Award (NSW Health Awards) 2008.

“Leaders are people who model good practice, challenge poor practice and inspire others”

Health Foundation
Stopping the spread of Multi-Resistant Acinetobacter (MRAB) in the Intensive Care Unit

Ms Larissa Hoyling
Clinical Nurse Educator, Nepean ICU
Sydney West Area Health Service

Mission:
To eliminate the transmission of MRAB in the ICU by December 2007.

Summary of the Project:
An Intensive Care patient with a Multi Resistance Organism (MRO) can increase cost, length of stay (due to complications or bed block) and ultimately increase mortality and morbidity. An increase in the transmission of MRAB occurred in the ICU during the months of August and September 2007. This project engaged a multi-disciplinary team including management, ancillary staff and clinicians of the ICU to work with the infection control department to address this issue.

Analysis
The project team reviewed the following: cleaning practices; hand hygiene audits; patient locality within the unit (related to transmissions); cultural issues; communication; antibiotic usage.

Intervention – plan and protocol
Once the issues were prioritised by the team, interventions were implemented by way of the ‘Plan, Do, Study, Act’ (PDSA) approach.

PDSA Cycle 1
After four cases of MRAB the following actions were implemented: high pressure water bed cleaning; damp dust environment cleaning; education sessions; use of blue impervious gowns for contact precautions; distribution of a VMO letter highlighting hand hygiene; increase in number and frequency of hand hygiene audits; increase in information from the Infection Control board; clinical waste audit.

PDSA Cycle 2
No MRAB transmission. Other MRO transmission minimal so all previous actions continued but with a more comfortable impervious gown to encourage compliance in the use of contact precautions.
**PDSA Cycle 3**
No MRAB transmission. Other MRO transmission minimal so all previous actions continued.

**Outcomes of the Project:**
Following implementation of the strategies, there remains a zero incidence rate in the transmission of MRAB, despite an increase in patients with Multi Resistant Organisms not attributable to the ICU. There has also been a reduction in incidence of colonised MRSA in a non-sterile site.

**Strategies for sustaining improvement:**
- Regular data collection, problem analysis and PDSA cycle review at monthly ICU;
- Infection Control meetings;
- Engaging floor staff with graded assertiveness training, education and performance feedback.

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**Sustainable Implant Procedures (SIMPL) at Liverpool Hospital**

**Dr Bruce French**
Director of Cardiovascular Stream
Sydney South West Area Health Service

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**Mission:**
The aim of the project was to develop a workable cardiac defibrillator implantation service at Liverpool Hospital (LH) within the cardiac catheter laboratory (CCL); to enable sustainable general anaesthetic (GA) capability in CCL at LH; and to facilitate more co-operative work practices between cardiologists, cardiac surgeons and anaesthetists working in the CCL.

**Problem:**
While predictable defibrillator implantation lists are part of a sustainable electrophysiology service, the patient must be stable for ventricular fibrillation induction, and high quality image intensification must be available.

At LH, there is implantation expertise within both the cardiology and cardiac surgery departments but there is no allocated theatre resource for defibrillator implantation. As a result, defibrillator implantation has been unpredictable and it has utilised nursing and theatre resources otherwise allocated to open heart surgery.
Prior to the project, pacemakers were implanted by cardiologists on Wednesdays and Thursdays, with urgent pacemaker implant cases often causing ‘over-run’ on the Wednesday list. Some pacemakers are not suitable for implantation via local anaesthetic and the pacemaker service was less sustainable with only two surgeons and no GA capability.

A GA is required to do percutaneous ASD but there were no available resources to enable anaesthetic support for ASD.

**Summary of the Project:**
A multi-disciplinary team was formed with representatives from anaesthesia, surgery, cardiovascular stream, critical care and nursing.

A flowchart of the current process was developed with an analysis of the issues impacting on service delivery. It was necessary to look at the specialty group interests and vulnerabilities. From this analysis, it was possible to develop strategies to improve the current service.

**Outcomes of the Project:**
- Development of a weekly defibrillation list for 3 out of 4 weeks in CCL.
- Inclusion in the defibrillation list of a time and resource allocation review facility to accommodate urgent pacemaker implantations.
- Development of a monthly (1 out of 4 weeks) list for percutaneous ASD closures scheduled with GA capability.

**Strategies for sustaining improvement:**
- Credentialling protocols for procedures to be appraised.
- KPIs for procedures to be monitored.

*What services / areas could benefit from adopting the same or a similar project?* The processes here, adjusted appropriately, could benefit any service where a particular condition or treatment is offered by more than one speciality group or where multidisciplinary management approaches are preferred.
The Children’s Hospital at Westmead

Statewide CLP
Maintaining best practice through adequate outpatient fracture management
Corinne Bridge

Reducing surgical site infection in the paediatric neurosurgical patient*
Raymond Chaseling
Winner NSW Health CEC Patient Safety Award

Safe Manual handling practice to maximise patient comfort and safety
Nicole Coburn

Velopharyngeal Function is appropriately documented in patients undergoing Reconstructive Speech Surgery
David Fitzsimons

Development Program for Babies and Toddlers with Achondroplasia*
Verity Pacey

ECG Education of ESW nursing staff
Gabbie Scarfe

Modular CLP
Transition of the GMCT to the Institute of Clinical Networks
Kate Needham

* see project summary
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<th>Module/Taskforce</th>
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<td>Transition of the GMCT to the Institute of Clinical Networks</td>
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<tr>
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<td>Improved medication safety via a streamlined personal development plan linked with competencies</td>
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<td>Redesign of the mental health inpatient unit’s clinical review process</td>
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<td>Implementation of a 23–hour surgical day procedure unit</td>
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<td>Improved paediatric speech pathology interventional services in outreach areas</td>
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<td>Consultative Teamwork approach to care by ambulance officers</td>
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<td>Midwife-VMO partnership to provide services to pregnant women in a safe and supportive environment</td>
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<td>Establishment of a stroke unit a rural facility</td>
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<td>Reduction in Door to Needle Time for Febrile Neutropenia</td>
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<td>An integrated Palliative care service to provide 24–hour support in a rural setting</td>
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<td>Culture/value based Induction and Orientation process for new staff within a Community Mental Health Team</td>
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<td>Falls prevention volunteer group project</td>
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<td>Pre–operative Physiotherapy Services for Joint Replacement</td>
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</table>
Reduce and minimise falls in patients over 65 years of age
Liz Simpson

Minimise functional deconditioning in the older person in the acute environment.
Basil Smagala

Reduce the proportion of hospital admissions experiencing a delay in discharge / transfer from hospital to alternative level of care
Mona Timo

Modular CLP
Multidisciplinary Clinical case review and audit process of inpatient deaths
Dr Lyn Currie

Greater Western Area Health Service

Statewide CLP
Development of standardised Clinical handover process using Digital Voice Recorder
Betty Byers

Identify and address the continence needs of elderly & disabled clients
Heather Clarke

Increase appropriate referral to outpatient cardio pulmonary rehabilitation program
Denise McCallum

Improved patient flow in the Fracture Clinic of a rural health service
David Sparshott

Modular CLP
Emergency Dental Roster in a rural setting
Dr Louis Christie

Diagnosis and management of Delirium
Dr Fran Gearon

Early Recognition of the Deteriorating Patient in a Rural Base Hospital
Dr Randall Greenburg

Hunter New England Area Health Service

Statewide CLP
Alignment of clinical practice with NSW Cancer Institute’s best practice guidelines
Maria Biancotti

Community Based Services Palliative Care Review
Alison Fielder

Delivery Suite Outpatient Flow
Jenny Haxton

Performance Reporting in the Ambulance Service to improve service delivery
Jeff Hescott
Improving the quality of psychological intervention through the routine use of outcome measures
Natalie McCall

A community based School Health Integration and Rehabilitation Team (SHIRT) framework
Lisa McGavern

Community and Post Acute Care (CAPAC): response to NSW State Plan
Sandy Ryan

Helping mothers and babies succeed at breastfeeding (HUSH)
Helen Scott

Mapping the patient journey in elective surgical care
David Smith

Prevention of Major Joint Infection – Hip*
Debbie Spokes

Area Implementation of Closed Head Injury Guidelines within ED
Felicity Wardle

Modular CLP
Medical Receiving Units and CAPAC Service design
Dr Michael Boyle

Implementation of Closed Head Injury Guidelines within ED departments across an AHS
Dr John Christie

Neonatal Transport “Look beyond the crisis”*
Dr Paul Craven

Use of SMS reminder system to reduce ‘non attendance’ at Outpatients department
Dr David Williams

Justice Health

Statewide CLP
Team Approach to Sharing Clinical Knowledge (TASCK) within Justice Health
Team Project: Amanda Richardson, Cheryl Davidson, Elizabeth Johns, Jennifer Woodward, Prue Cobb, Ray Dowling, Ros Pavey

Modular CLP
Improving access to community forensic mental health service for those with high risk needs
Dr Steven Allnut

On call rostering
Dr Virginia Noel

* see project summary
North Coast Area Health Service

**Statewide CLP**

- Improving physical health for people with a mental illness*
  Fiona Beston

- Improved discharge of frail elderly patients to their pre-admission place of residence
  Ann Bourke

- The Mother–Baby Continuum*
  Jo Campbell

- Improved accuracy of documented information in transferring patients from ED to the ward
  Susan Gambetta

- Increased uptake of alternate birthing options within a rural facility
  Louise Harper

- Pharmacist in ED to list medication details for patients over 65 on more than five medicines*
  Margaret Hewetson

- Falling and Malnourishment – the Occupational Therapy Link*
  Rosie Kew

- Managing patients at risk of falls by improved physiotherapy referral and prioritisation processes
  Christine Minto

- Improved referral and early detection of speech pathology needs in 0–3 years age group
  Jane Ossedryver

- Increased recognition and recording of pain at triage
  Alan Pretty

- Timely provision of ECG for ED patients presenting with acute coronary syndrome
  Michael Steenson

- Improved completion of consent forms on pre-operative urology patients in order to reduce delays
  Roz Wagner

**Modular CLP**

- Express Community Care Centre for aged care patients in a rural setting
  Dr Alan Forrester

- Demand management plan and policy development
  Dr Geoffrey Ramin

- Introduction of policy to improve patient flow through Emergency Department
  Dr Alan Tankel
Clinical Excellence Commission
Northern Sydney Central Coast Area Health Service

Statewide CLP
Development of a website to keep physiotherapy staff up to date on best practice
Glen Auld

Cannabis “Stepped Care” Project to improve successful completion rates
Steve Childs

Patient Flow – Risk assessment, care and discharge planning
Mironne Golan

Timely notification of Breast Screen results
James Guinan

Improved clinical assessment orientation process for casual nursing staff
Alison Harris, Donna Joel

Engaging carers for more person–centred care
Dr Sian Keane

Improved GP and private psychiatrist communication on admission and discharge
Neil Maclean

Appropriate treatment of leg ulcers in Community Patients
Joanne MacMillan

Increasing access to health services for children in ‘out of home care’
Nicole McDonald

Improved access to community follow up for patients who have had insertion of a PEG tube
Julie McFarlane

Effective case management and contracting for Community Nurses
Leanne McLaren

APAC Admission Documentation Project
Lisa Scaturchio

Care Planning for GP Shared Care
Paul Smith

Needle and syringe program to reduce the transmission of Hepatitis C in people injecting drugs
Graham Stone

NSCC continuum of Care Program
Marie-Helene Vrolyk

Development of a Risk Assessment Tool for Area Paediatric Units
Professor Garry Walter

Assessing cognitive deficits with post–stroke clients in their own home
Therese Wellsmore

* see project summary
Appropriate Oral Health Assessment for Specialised Services
Naomi Wilson

Modular CLP
Review and strategic planning of paediatric services in a Metro Area Health Service
Dr John Erikson

Out of hours Management of # NOF
Dr Anne Greer

Recommendation for Surgical Admission
Ms Jan McCaig

Provide strategic direction and prioritization around Paediatric clinical governance for NSCCAHS
Ms Liz Mitchell

Sydney South West Area Health Service

Modular CLP
Management of Acute Abdomen
Dr Neil Berry

Sustainable Implant Procedures (SIMPL) at Liverpool Hospital*
Dr Bruce French

Radiation Oncology Information Exchange Project
A/Prof Chris Milross

An effective oral health care assessment pathway for pre-surgical and medical patients
Dr John Powers

South Eastern Sydney Illawarra Area Health Service

Statewide CLP
Improving orientation for families of clients new to inpatient Mental Health Units
Project Team: Kim Brookes, Sonya Bubnij, Vanessa Clements, Mardi Daddo, Jan Heiler, Marie Hodgetts, Angela Karooz, Kathy North, Ann Schiller, Shelley Tranter

Better Understanding Deterioration (BUD) in adult inpatients
Joanne Coleman, Lynda Craig, Louise Dunne, Michelle Holton, Adele Kelly, Susie Kerr, Tanya Tosich, Karen Tuqiri, Richard Yarlett

The Right Moves: Reducing the incidence of clinical risk in inter–hospital transfers
Project Team: Peter Cribbs, Kariene Dwyer, Michele Mathieson, Pam McAllan, Nilda Miranda, Linda Morrissey, Terry Morrow, Bernadette Woods

Modular CLP
Radiology Quality and Safety Program
A/Prof Barry Elison

Appropriate use of Albumin
Dr Steven Katz
Improving collaboration across Cardiac Surgery Services  
Dr Michael McGlynn

A model for Paediatric Rapid Response Teams  
Dr Jonny Taitz

Sydney West Area Health Service

Statewide CLP  
Impact of Angiography and Haematoma on patient safety  
Anne Marie Allen

The patient journey in Hookwire localised excision biopsy  
Elisabeth Black

Improvement of Bedside Nursing Documentation  
Katherine Cox

Team development within the Special Care Nursery  
Therese Freeman, Debbie Green

Scheduled Toileting of Older People at Fall Risk – STOP FALLR Project  
Christine Giles

Stopping the spread of Multi–Resistant Acinetobactor in ICU*  
Larissa Hoyling

Management of pregnancy beyond term  
Julie Mate

The Impact of Oral Hygiene Practices on the Dependent Neuroscience Patient  
Joanne Phillips, Sharen Rogers

Establishing a Triage/Intake System  
Julie Strukovski

Migration of chest pain through Emergency Department  
Scott Williams

Modular CLP  
Funding Challenges in providing a Statewide Bone Marrow Transplant Service  
Dr Warwick Benson

End–of–Life Care Planning*  
Dr Michael Datyner

Implementation of correct site and time out policy along with standardisation of pain management forms  
Mr Paul Summers

* see project summary
CLP Participant Testimonials

What past participants say about the program

“Applicable, surprising, broadened my thinking about what is achievable.”
Consultant Neurosurgeon

“I have greater confidence in leading a multidisciplinary team and a better understanding of my own management style.”
Network Director

“Has improved my ability to focus on the priority areas of clinical health delivery and to be more globally aware”
Cardiothoracic Surgeon

“You cannot be a leader, and ask other people to follow you, unless you know how to follow, too.”
Sam Rayburn – Congressman and long–time speaker of the United States of America House of Representatives
## Acknowledgements

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<tr>
<td>Paul Crowe, Helen O’Grady</td>
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<td>Ketty Rivas, Karen Patterson</td>
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<td>Richard Tewson, Loretta Martin</td>
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### CLP Program Leaders 2007/08

**Clinical Excellence Commission**

Bernie Harrison , Mary Mitchellhill, Annette Solman Colleen Leathley, Teresa Pudo

**Compiled and edited by**

Teresa Pudo

Kay Wright
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