Improving antibiotic surgical prophylaxis

Dr Alison Winning, Infectious Diseases Physician and Microbiologist, The Tweed Hospital

Driver Diagram

**Aim Statement**
Within 12 months, 100% of antibiotic surgical prophylaxis will be prescribed appropriately

**Background**
Increasing antimicrobial resistance is a major public health concern. While rates of antimicrobial resistance are increasing, few new antibiotics are being developed. One of the drivers of antimicrobial resistance is inappropriate antibiotic use. In addition to resistance, inappropriate antibiotic use results in poorer patient outcomes, increased side effects, and increased healthcare costs. Inappropriate antibiotic use may require unnecessary screening of bacteria for viral infections, using broad-spectrum agents when a narrow-spectrum agent would be effective, using incorrect dose or duration of antibiotics, as well as prolonging, incorrectly timed or unnecessary surgical prophylaxis.

Surgeries prophylaxis has been the common reason for antimicrobial prescribing in hospitals for the past 5 years in a national survey (NAPS). Evidence shows that for certain indications, preoperative antibiotics can reduce the rate of surgical site infections, and guidelines for surgical antibiotic prophylaxis have been issued by a number of professional bodies. However, a recent national survey showed that 43.4% of surgical prophylaxis in Australian hospitals were inappropriate. An survey performed at The Tweed Hospital showed similar results: see figures below.

**National Standard 3**
As part of National Standard 3, health facilities are required to have an Antimicrobial Stewardship (AMS) program in place. The AMS program must include monitoring of antimicrobial prophylaxis and evidence of action to take to improve antimicrobial prophylaxis prescribing.

**Plan-Do-Study-Act Cycles**
1. Develop local surgical prophylaxis guidelines – collaborative approach
   - Previously there have been no local surgical prophylaxis guidelines at TTH
   - Practice variable between surgeons
   - Therefore guidelines were developed and feedback sought from surgeons and LHD AMS teams
   - To be followed by implementation with education to medical and nursing staff

2. Meet with surgeons to address specific issues
   - Outlying prescribers identified by audit
   - Meeting arranged with surgeons and literature review
   - Performed to address specific concerns
   - Ongoing monitoring and feedback

3. Standardise MISSA/MRSA screening before joint replacement
   - Previously screening for Staph colonisation not routine
   - Liaison with orthopaedic team and preadmission clinic regarding implementation of screening
   - Protocol for screening and staph load reduction developed

4. Change from vancomycin to teicoplanin for MRSA cover
   - Identified that vancomycin is given appropriately in majority of cases due to long infusion times.
   - Teicoplanin is an alternative that can be given as a push
   - Guidelines developed for teicoplanin use, to be submitted to Hospital Pharmacy Committee
   - Monitoring of appropriateness of prescribing, costs and adverse effects

**Results**
Within 6 months of implementation, the following processes, outcome and balancing measures will be reviewed

- Surgical National Antimicrobial Prescribing Survey (SNAPS)
- Audit of clinician awareness of guidelines
- Audit of MISSA/MRSA screening and load reduction

**Drivers**
- **Primary Drivers**
  - Increase knowledge of surgical antibiotic prophylaxis
  - Promote antimicrobial stewardship
- **Secondary Drivers**
  - Increase education about antimicrobial prophylaxis guidelines
  - Improve post-operative antibiotic rescue processes

**Solutions**
- Develop local surgical antibiotic prophylaxis guidelines
- Liaise with surgeons and preadmission clinic
- Collaborate with surgeons reinforcement
- Improve preoperative antibiotic profiling
- Increase ID and surgical interactions

**Plan to sustain and spread change**
To ensure that change is sustained longer term, the following measures will be put in place:

- Sustaining knowledge
  - Education about prophylaxis guidelines included in orientation programs
  - Development of any cards and sheets for clinicians
  - Promotion of guidelines during Antibiotic Awareness Week

- Sustaining monitoring
  - Standing agenda item on AMS committee meetings
  - 6 monthly SNAPS (Surgical National Antimicrobial Prescribing Survey) undertaken by surgical trainees.

- Sustaining feedback and collaboration
  - 6 monthly SNAPS presented at surgical M&M meetings and emailed to heads of surgical departments
  - Appointment of junior doctor AMS champion

**Team members**
- **Project Team**
  - Alison Winning, ID physician and Microbiologist
  - Lydia Che, AMS pharmacist
  - Kristin Ryan-Agnie, Infection Control CNC

- **Executive Sponsor**
  - Nilesh Parmar, Deputy Director Medical Services

**References**
- Australian Commission on Safety and Quality in Health Care - Guidelines: Antimicrobial Prescribing: Guidelines for inpatient hospita
- National Sentinel Antimicrobial Prescribing Survey - Surveillance and Reporting System 2017-2018

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A Clinical Practice Improvement Project
**AUTHORS**

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**INTRODUCTION**

Transfusion is frequently required in neonates requiring intensive care management. The Neonatal Intensive Care Unit (NICU) at the John Hunter Children’s Hospital (JHCH) is one of the largest in New South Wales, and provides state of the art, comprehensive care specialty to newborns. With 38 intensive care and 24 special care beds, it cares for more than 1100 newborns annually. More than 150 units of blood and blood products were prescribed to neonatal patients in 2015. In keeping with the release of Patient Blood Management (PBM) Guidelines: Module 6 Neonatal and Paediatrics,1 we aimed to ensure excellence in transfusion practice in the Neonatal Intensive Care Unit (NICU) and to align local policies and practice to provide appropriate use of blood components in this vulnerable population.

**METHODS**

Clinical Practice Improvement (CPI) methodology was used to determine interventions and key data monitoring.

Previous Standard 7 audits were reviewed and a baseline transfusion practice audit was collated. NICU staff received additional professional training in obtaining informed consent, prescription of blood components, and the safe administration of blood components. A NICU-specific parent handout about transfusion (largely informed by partnership requirements for neonates). In consultation with NICU staff (doctors, neonatal nurse practitioners and nurses), a program for additional training in blood administration of blood components. A NICU-specific parent handout about transfusion (largely informed by partnership requirements for neonates).

Parental knowledge, concerns, and feedback regarding transfusion practice was sought at baseline (survey) and upon completion (improvement tracker). Feedback from the NICU staff (a mix of medical and nursing) regarding the additional transfusion training and parent handbook was also collated.

**DISCUSSION**

Adequate audits have shown that there has been inconsistent consent, monitoring and documentation processes in neonatal transfusions in our institution in the past, and there are many causes contributing to this issue (figure 1).

In consultation with NICU staff (doctors, neonatal nurse practitioners and nurses), a program for additional training in blood transfusion specifically focused on newborns was steered. The combination of lectures, practical workshops and laboratory education was labeled ‘Blood Month’ and took place in February 2018. Materials included:

- an overview of evidence based transfusion practice in neonates, including working areas of research (including transfusion research currently being undertaken within the JHCH/NICU)
- a review of the Standard 7 requirements for the consent, prescription, administration and documentation of blood and blood products (including electronic in-patient order entry/bedside workarounds to help avoid errors made in this process), and
- an overview of the laboratory processes involved for blood and blood products with an emphasis on the additional requirements for neonates.

One of the barriers to consent identified by the NICU staff was the lack of neonatal-specific information available to give to parents and families during the consent process. To avoid this a specific handout was developed, in collaboration with parents, to provide concise, easy to read and accurate information about blood transfusion. To ensure that the needs of parents were being met, a short survey was offered to parents in the NICU to identify what they perceived to be important content for the handout.

**RESULTS**

Baseline audit showed inconsistent consent, monitoring and documentation processes in neonatal transfusions. Post-pilot audit showed improvement in these parameters.

**ACKNOWLEDGEMENTS**

Australian governments fund the Australian Red Cross Blood Service to provide blood, blood products and services to the Australian community. Our partners in ensuring excellence in neonatal transfusion practice are John Hunter Children’s Hospital Newcastle, Calvary Mater Newcastle and HNEHD clinical operations.

**REFERENCES**


Assertive Outreach
When Standard Care Isn’t Enough

Aim Statement:
To provide “Intensive Extended” phase of care treatment to at least six people engaged with HVMHS by 31st December 2018

Background to problem worth solving
Known service gap contributing to poor outcomes for clients, staff and organisation

Team members
- Sponsor/ (Guidance Team) Leanne Johnson General Manager Hunter New England Mental Health Network
- Project Team
  - Team Leader – Darren Bowd Service Manager
  - Dr Sharon Crabbe Clinical Director
  - Mandy Smith Clinical Coordinator
  - Amanda Kelly Team Manager non-Acute
  - Anna Dunbar Clinical Nurse Consultant
  - Luke Johns Senior Occupational Therapist
  - Sarah Campbell Senior Social Worker
  - Jane Bonfield Registered Nurse
  - Jessica Turnbull Occupational Therapist
  - Consumer Participation – Edith Newton

Link to National Standard or Strategic Imperative
- Standard 5 – Comprehensive Care
- Activity Based Funding via AMHCC

Literature review
- Australian Mental Health Care Classification Participant’s Manual
- Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia ad related disorders

Change concept 1
Assertive Outreach roster developed
Staff identified in advance
- Equitable
- Facilitates individual work planning of this and other functions
- MDT

Change concept 2
Daily clinical meetings held with
- Regular member attendance
- Run by Team Leader/Senior Agenda including
  - Review of all current client care and client progress
  - Next actions discussed, confirmed and allocated to staff on assertive outreach roster
  - New referrals presented and considered
- Formatted documentation
- Formatted activity reporting in electronic record

Change concept 3
Parameters to indicate Assertive Outreach
Development of a “problem set” covering six domains representing the full range of concerns, their measurement and application

Results
Outcome measures

Process measures
Contact Frequency

Balancing measures
Standard Care Performance

Discussion
Assertive outreach is resource intensive – more care to a few people with very high need. Consideration still needs to be given to many people that would benefit from standard care

Overall Outcome of Project:
Goal achieved early and sustained for life of project, but not sustained in becoming an ongoing practice.
Even modest numbers of clients (such as the goal) require a high level of organisation and resource for the care to be reliably and sustainably provided.
Workloads require active monitoring to support staff

More contact = better engagement = better outcomes

Plans to spread /share change
Learnings to be used to inform development of new model of care for adult community mH services in HNELHD
Revisit during implementation of same
For now, the gap remains, the costs remain
Improving the Accuracy of EDDs - OHS Medical Ward

Aim Statement:
By June 2019, 80% of patients will be discharged from the medical ward on their identified EDD.

Background:
Less than 50% of patients are discharged from the medical ward on their identified expected date of discharge (EDD). This impacts on facility planning and patient journeys.

Team members
Sponsor (Guidance team) members:
Lacey Healey – Executive Sponsor
Dr Geoffrey Chu – Medical Head of Department

Project Team
Donna Smith – Project Lead
Lacey Healey – Head Allied Health
Anetta Westgeest – NUM Medical Ward
Fiona Tudor – CNS Medical Ward
Dr Huizhong He- Medical Registrar
Consumer involvement through interviews & surveys of staff, patients and families

Driver Diagram
The Problem:
50% of patients in the Medical ward are discharged on their identified EDD

By June 2019 80% of patients will be discharged from the medical ward on their identified EDD

Primary Drivers
Increase Medical Officer participation in updating EDDs
Increase ward staff participation with updating EDDs
Increase accuracy of information on Patient Care boards
Increase patient/carer knowledge of their expected EDD

Secondary Drivers
Increase staff knowledge of EDDs and impact on Predictive tool
Improve communication by teams to COS of updated EDD
Increase COS rounding with medical teams
Increase EDD update on PPP prioritisation
Increase Patient awareness of EDD though discussions by staff with them
Increase completion & update of Patient Care Boards
Identify barriers to discharge early in admission to allow early intervention

Change ideas
COS to discuss EDDs at MST daily meetings
Schedule staff to receive education on EDDs & PPP interventions during orientation
Teams to liaise with COS during or after rounds – ward MD who communicates the most EDD updates over 2 week period
Medical officers to document EDDs in patients notes
COS to try to attend medical rounds as a priority
Medical staff to discuss each patient’s EDD with them on rounds
Discuss Patient Care board competency at ward meetings – ward to nurse who has most complete patient care boards over 2 week period
Discuss barriers to discharge with each patient and/or carers

Process Measures:
Process Measure:
How much: 75% of patients have completed Patient Care Boards
By when: March 2018

Process Measure:
How much: Increase patient knowledge of EDD by 25%
By when: November 2018

Process Measure:
How much: No increase in 28 day readmission rate
By when: June 2019

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

Results
Outcome measures
A sustained reduction in the percentage of discharges on the identified EDD that was below 50% was achieved.

Process measures
An identified process measure was to increase patient knowledge of their EDD by 25% by November 2018

An initial and progress survey of patients identified that there had been:
- 37% increase in nurses discussing EDDs with patients
- 45% increase in discussions identifying discharge needs

Plans to sustain change
Standardisation:
Our focus is on embedding practices into roles/positions not individuals for sustainability

Documentation:
Utilisation of the Patient Flow Portal tools allows clear and transparent information and capacity to monitor through reports

Measurement:
The Patient Flow Portal enables real time and retrospective data collection and collation

Training:
The Patient Flow Portal enables real time and retrospective data collection and collation

Plans to spread/share change
It is the intention to ensure sustainability of the processes when embedded in the Medical Ward and then to scale across the facility.

OHS is always willing to share and exchange ideas with other organisations.

Lessons learnt
- Change takes time to embed – it must be nurtured
- Sometimes you need to take a step backward in order to move forward
- The composition of the team and team engagement is vital
- Celebrate the small successes
- Encouragement can come from the most unexpected places
Feasibility of an Exercise Program for patients post autologous bone marrow transplantation (ABMT) at Nepean Hospital Cancer Services

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ECLP Cohort 20

Aim Statement:
By February 2019, 80% of ABMT patients enrolled complete the outpatient exercise program.

Background to problem worth solving
- Patients who have undergone autologous bone marrow transplantation (ABMT) experience significant fatigue and physical deconditioning due to the therapy process and prolonged periods of inactivity while on confinements during hospital admission
- Patient attendance in the program was limited (59%) due to individual needs
- Overall attendance in the program was limited (59%) due to individual needs
- Feasibility of an Exercise Program for patients post autologous bone marrow transplantation (ABMT) at Nepean Hospital Cancer Care Centre for any cancer type
- In 2018, 22 patients received ABMT at Nepean Hospital

Team members
- Team Lead – Elizabeth Calleja
- QI Advisor – Michael Wood
- Consumer – Monica Vince
- Team members
- Alicia Calleja – Clinical Nurse Consultant Apheresis and Bone Marrow Transplantation, Nepean Cancer Care Centre
- Glyndon Wakeman – Senior Physiotherapist, Nepean Cancer Care Centre
- Laura Kirsten – Principal Psychologist, Nepean Cancer Care Centre, Lead Clinician Psychology, NBMLHD
- Louise Maher – Clinical Nurse Consultant Oncology, Nepean Cancer Care Centre

Link to National Standard
- Standard 2
Partnering with consumers
- Literature review

Driver Diagram
- The Problem: Patients undergoing autologous bone marrow transplantation (ABMT) experience significant fatigue and physical deconditioning due to the therapy process and prolonged periods of inactivity while on confinement during hospital admission
- Objective: To develop a program to address the needs of patients post-ABMT
- Background: The importance of exercise therapy for cancer patients
- Aim Statement:
- By February 2019, 80% of ABMT patients enrolled complete the outpatient exercise program.
- By February 2019, 80% of ABMT patients enrolled complete the outpatient exercise program.

Results
Outcome measures
- Psychological Measures
  - Fatigue: Before and After 8 week exercise program using the Fatigue Symptom Inventory (FSI), 44% improvement in symptoms of Fatigue
  - Quality of Life: Before and After 8 week exercise program using the FACT-BMT inventory, 12% improvement in Quality of Life

Physical Measures
- Leg Strength: Before and After 8 week Program, 21% improvement
- Six minute Walk Test: Before and After 8 week Program, 17.5% improvement

Plans
- Plan to spread/share change
  - 2019 Plans
    - ACI Innovation Exchange
    - ACSI Blood and Marrow Transplant Network
    - Allied Health Grand Rounds 2019
    - NBMLHD Quality awards 2019
    - Allied Health Grand Rounds 2019
    - NBMLHD Quality awards 2019
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    - Allied Health Grand Rounds 2019
    - NBMLHD Quality awards 2019

Change concept 1 - PDSA Cycle
- Testing a Change Idea via a PDSA Cycle

Change concept 2 - PDSA Cycle
- Testing a Change Idea via a PDSA Cycle

Change concept 3 - PDSA Cycle
- Testing a Change Idea via a PDSA Cycle

Overall Outcome of Project:
- As this project was an initial PDSA, not all patients eligible for the program were assessed for the first intake of the 8 week program. This was limited due to clinic time
- Of the patients that completed (75%), 44% had a decrease in fatigue and demonstrated improvements in physical function with the six minute walk test (17.5%) and leg strength (21%) assessments.
- Patients enjoyed the exercise program and would recommend it to other patients
- Patients were able to complete exercises set, and nil adverse events were caused due to the exercise sessions

Plans to sustain change
- Writing of and submission to local enhancement bids and network funding grants to continue the program led by an exercise physiologist (EP)
- Training of EP and physiotherapists at NBMLHD, up-skilling of staff on exercise for cancer patients via HETI grant. This will be completed via “ExMed Cancer” training course for exercise therapy during and post cancer therapy
- In-services to staff to raise the awareness of the importance of exercise therapy for cancer patients
Domestic Violence Routine Screening (DVRS) in the Child and Family Health Program.

**Aim Statement:**
Within 6 months, increase the rates of Domestic Violence Routine Screening to 70% in the Child and Family Health Nurse program.

**Background**
- DV affects the physical, psychological and social health of many women and children. Globally, 30% of women who have been in a relationship have experienced DV (Snider 2009).
- Routine screening in NSW Health services commenced in 2003. Screening has resulted in increased identification and referral to services to support women and children.
- Historically, an annual one-month snapshot was used to measure screening rates. In 2018 quarterly data has been extracted.
- Electronic data collection provided an opportunity to assess screening behaviour and rates locally.

**Driver Diagram Template**

**Primary Drivers**
- Improve Communication
  - Process Knowledge: How much feedback to clinicians
  - By when: October 18
- Better use of Technology
  - New tools: Technology to improve screening (DVRS)
  - By when: Oct 18
- Increase Education
  - How much: Monthly training to all staff
  - By when: December 2018
- Presence of Partner/Other
  - How much: Increase partners
  - By when: October 18

**Secondary Drivers**
- Access to female Interpreter Services
- Information prior to visit
- Nurse feedback on rates
- Use of Alerts on EHR
- Extract data and feedback to staff
- Access to tablets

**Change Ideas**
- Run education sessions at quarterly forum
- Extract DVRS data monthly and feedback low 10
- DVRS screening rates included on CFHN Agenda

**Discussion**
- Results indicated that with the introduction of immediate feedback to clinicians giving them their screening rate for the month increased screening behaviour. Highest increase seen PDSA 2.
- Placing screening rates on Agenda at Child and Family Health Nurse Forums by town/cluster also increased screening rates PDSA 3
- Smaller increase seen in education provided to nurses PDSA 1

**Overall Outcome of Project:**
Our stretch goal was reached – 70%

**Plans to sustain change**
How will we sustain these gains into the future with the improvements we have made?
1. Standardisation of training for all new CFHN staff include the DVRS Screening training. Ongoing quarterly agenda item on CFHN Forum. NUM’s have included in monthly Monthly Accountability Meetings (MAM’s).
2. Documentation will continue and screening rates will be extracted monthly (reported quarterly to MoH).
3. Measurement – Data will be monitored monthly and the ‘bottom 10’ will be identified and ‘top 3’
MoHiTo project: Management of Intravenous Heparin Therapy Out west

Fiona Bailey Medication Safety and Quality Officer Fiona.Bailey@health.nsw.gov.au

ECLP Cohort 19

Aim Statement: By August 2018, 95% of patients admitted under the cardiology clinical service at Westmead Hospital who are receiving intravenous heparin therapy, will receive appropriate care that complies with WSLHD intravenous heparin therapy prescribing, monitoring and administration guidelines.

Background to problem worth solving: Incidents resulting in patient harm related to and lack of understanding of heparin protocols and nonadherence to guidelines.

Sponsors (Guidance team) members:
- Dr Jennifer Cumow, Director Clinical Haematology - WSLHD
- Dr Robert Dennis, Cardiology Head of Department – Westmead Hospital

Project team members:
- Helen Crowther
- Matthew Han
- Jill Squire
- Lorraine Koller
- Christine Coorey
- Margaret Murphy
- Leo Pasalic
- Gajan Kalainathan
- Mehmet Harapoz
- Sumita Barua

Quality Advisor:
- Catriona Middleton-Rennie

Consumer representative:
- Anna de Wet

National Standard Medication Management Processes – High-Risk Medicines:
- a. Identifies high-risk medicines used within the organisation
- b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

Project addressed the following requirements:
- Monitoring and analysis of incident reports
- Audit compliance with protocols
- Safe prescribing and administration
- Training requirements

Results: Outcome measures

Process measures

Discussion:
No significant bleeding events were noted during the project. The project resulted in an improvement in patient care by decreasing the time to the first therapeutic blood (aPTT) result by 40%.

Overall Outcome of Project:

Plans to sustain change

Standardisation
- Pathology has been included in order sets
- Introduction of pre-mix intravenous heparin solution
- Plans for an alert when pathology results available

Documentation
- New intravenous heparin protocol

Measurement
- Move to EMM will allow for auditing
- JMO training sessions at start of each new term

Plans to spread/share change
- Incorporate learnings into state-wide initiatives
- Submit abstract to SHPA 2019 conference
- Submit to ACI Innovation exchange
- Submit abstract to International Forum in Safety and Quality in Healthcare 2019 conference
Aim Statement:
Within 6 months, referral processing time for adult community Occupational Therapy clients will reduce by 45% resulting in appropriate service alignment.

Background to problem worth solving:
Change to referral process with the introduction of My Aged Care (MAC), navigating the MAC portal and increase in OT private providers. Resulted in high rates of referral recalls that had already been processed by the CACC OT service. Impacting on clinician time and referral confusion.

Sponsor/s (Guidance team) members:
- Kevin Hedger Director of Allied and Population Health
- Michelle Dunsari Operations Manager CACC
- Joanne Silver A/Connecting Care Integration Manager

Project team members:
- Gillian Menear Senior OT
- Kathy Sweeney A/Senior OT
- Emma Pereira A/Senior OT

Consultation:
- PC&CH Central Intake Service Team Leader and Administration Officer
- ACAT & RAS NBMHD Team Leader

Driver Diagram

Overall Outcome of Project:
- $ Cost saving
  Jan 2018 – Oct 2018 Original process - all MAC referrals processed into CACC OT Service
  186 MAC referral recalled by private providers
  5 stage referral/riage/MAC discharge – 26 minutes
  263 hours costing OT/Adm $47.00 = $12361

PSDA Nov 18 – Jan 19
- 10 MAC Recalls at 20 mins
- 3 hours costing $141

Forecast
- Recalls average 3 per month for 12 months = 36 recalls. Cost $556
- Compared to average of 15 recalls/month in the old process = 180 recalls $11885 + $91241 per year
- Service hours saved = 243 hours/year

Plans to sustain change
1. Standard practice within CACC OT service. Potential of other allied health services.
2. Finalise OT referral management procedure
3. Continue measurements as part of monthly report to service managers.
4. Ongoing data monitoring of all OT ref triaging and recalls
5. Training OT team is advised of system updates, training modified and management procedure updated to reflect system or process change.

Ongoing collaboration with key partners

Plans to spread /share change
- Allied Health CACC services, OT within LHD and other LHDs working with MAC
- LHD Quality Award July 2019 submission
- ACI Innovation Exchange
Identifying the Deteriorating Mental State of Consumers in Adult Community Mental Health Teams

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ECLP Cohort 19/20

Aim Statement:
Within 6 Months 95% of files audited will have a clearly documented Mental State Examination, Risk Assessment Formulation and Care plan.

Team members
Sponsors:
- Alison Thorne

- Project Team – Jacinta Elphick
- QI Advisor – Sonya Bull/ICEC
- Consumer – Barbara Hall & Spencer McGill

Link to National Standard or Strategic Imperative
- 2 Partnering with consumers
- 5 Comprehensive Care Standard
- 6 Communicating for Safety Standard
- 8 Recognising and Responding to Acute Deterioration Standard

Literature review
The literature review focused on two elements. 1. What makes a safe and high quality CMH service? and 2. What is best practice when identifying the deteriorating mental state of MH consumers? The list below is a sample only.

Change concept 1 - PDSA Cycle
- Testing a Change Idea via a PDSA Cycle:
  1. Plan your change
  2. Act on the idea
  3. Study the change
  4. Reiect or repeat

Change concept 2 - PDSA Cycle
- Testing a Change Idea via a PDSA Cycle:
  1. Plan your change
  2. Act on the idea
  3. Study the change
  4. Reiect or repeat

Change concept 3 - PDSA Cycle
- Testing a Change Idea via a PDSA Cycle:
  1. Plan your change
  2. Act on the idea
  3. Study the change
  4. Reiect or repeat

Results
Process measures (graphs)
- Results – Impact of the Change Ideas tested via PDSA
- Run Chart of MH In-Patient Risk Assessments Compared
- Combined Baseline, Post and Project Results
- Operational Definition, Initiation, Documentation, MI, Risk Assessment, Consumer/ Family Engagement

Discussion
The project has highlighted that there is very little evidence and research on how to identify a consumers deteriorating mental state in a timely or systemised manner. The current evidence supports the use of a repeated MSE and Risk assessment in conjunction with a comprehensive mental health assessment with collaborative information as the only reliable way to monitor and detect mental state deterioration. The research also highlighted the need to prioritise consumer and carer reports of changed behaviour when deciding urgency of response, being aware that consumers don’t improve as a risk factor and recognising that behaviour changes that indicate mental state deterioration are unique to each individual. This can be difficult for rural CMHDA clinicians to achieve in a timely manner given their isolation level of acuity and fluctuating workloads. Clear documentation that can be easily located within the eMR and understood between clinicians and services was another issue highlighted along with time opportunities for reflecting on consumers mental state and knowing when and how to escalate care. The other issues identified by research was the idea of safety culture within teams and what that looks like in CMHDA teams.

Overall Outcome of Project:
We reached our stretch goal for documented MSE’s with a care plan. This needs to be transferred to choc documentation to be easily identified by all MLHD MHDA services.

The project is still progressing and we are yet to see if our overall goals will be met.

Plans to sustain change
- 1. Standardisation
- Once the team is happy with an approach to obtaining documenting reviewing and escalating the information in clinical decision making we will present to other CMH teams in MLHD.

- 2. Documentation/Measurement
- We will continue to collect data on a regular basis and remind teams of where the documentation needs to occur for easy access.

- 3. Training
- Training has commenced District wide on Clinical Formulation. We would like this to be expanded to include a standardised approach to documenting MSE’s.
- We would also like to see a shift in practice to include Family/Carer and consumer concerns about changing mental state seen universally as a red flag for deteriorating mental state along with gaining collaborative information and identifying individual early warning signs and developing safety plans with that in mind.

Plans to spread/share change
Spread findings across MLHD Community Mental Health teams

Source funding and a research partner to measure the efficacy of implementing the Australian Commission on Quality and safety in Health Cares proposed clusters and signs of mental state deterioration
Accelerated access to Hepatitis B vaccination for prisoners

**Aim Statement:**
By January 2019, increase the rate of Hepatitis B vaccination for prisoners residing in Metropolitan Special Programs Centre (MSPC) Area 1 at Long Bay Gaol by 10%.

**Background:**
Research shows that vaccinating prisoners in custody increases vaccination cover for people who inject drugs and are most-at-risk for Hepatitis B (HBV) infection.

**Team members**
- **Sponsor (Project Guidance):** Terri Sheehan (Operational Nurse Manager)
- **Project Team Members:**
  - Kristen McKee (Transitional Nurse Practitioner)
  - Kim Campbell-Davis (Clinical Nurse Specialist)
- **Data Advisor:** Greg Cheguelman (Surveillance Officer)
- **Quality Advisor:** Michelle Eason (Director, Organisational Development Unit)

**Driver Diagram**

**Primary Drivers**
- Wear not changed over (2)
- Need not bagged at reception
- Patient away/refused
- Staffing levels of Healthcare CNSW staff (2)
- PH nurse too many other things to do
- Pt. movement between centres
- Lockdowns (4)
- Patient refusal due to lack of understanding
- Consulting planned appointments
- Patient don’t know when patient moves centres (2)
- Disruption on computers

**Secondary Drivers**
- Long waiting lists (2)
- Timing of EDP
- Not efficient to vaccinate
- Staff acting up not back filled
- No clinic space available (2)
- Patients need nurse not want to be vaccinated

**Process**
Meetings and focus group discussions were held with nurses and managers to identify opportunities to improve vaccination:

- Vaccination accreditation for registered nurses requires attendance of a 150 hour course and may result in leaving vaccinating to “champions”
- Staff reported confusion about vaccinating and reporting of vaccinations
- If no medical officer is available, nurse must phone after hours service for authorization and complete additional paperwork.
- PHN reported an inability to screen all new prisoners for BBV in a timely manner.
- Confusion about the patient administration system (PAS) and wait-listing of patients for vaccination by Primary Care Nurses

**Baseline levels of HBV vaccination**

1st – 3rd doses at MSPC clinics 01/06/2017 – 31/05/2018

**Outcomes:**
- New code introduced September 2018 allows direct measurement of HBV vaccinations.
- New standing order approved in December 2018 for piloting at Long Bay Gaol.
- Early data reports show good reporting of HBV vaccination at the pilot site and increased vaccination at control sites
- A low rate of vaccination amongst Indigenous prisoners was identified and addressed in December 2018

**Plans to sustain change:**
This research will be expanded into a more substantive research program in 2019 to address the low level of monitoring of chronic HBV infection

**Plans to spread / share change:**
- Continue to feedback results to nursing staff
- Publish substantive research findings
- Share with ACI
- Enter as quality award
Two Steps Forward: Building healthy habits for long-term health outcomes in children and adolescents with severe obesity

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Background

1 in 4 children (aged 2 – 17yrs) in NSW are affected by overweight and obesity which is known to have significant impacts on physical health including hyperlipidaemia, hypertension, insulin resistance, decreased pulmonary function, sleep apnoea, hepatic steatosis, polycystic ovary disease and orthopaedic complications. Children who are overweight and obese are also at risk of developing psychosocial complications such as poor self-esteem, depression and eating disorders. Rates of overweight and obesity in children have been increasing.

Tackling Childhood Overweight and Obesity was identified as a NSW Premier’s Priority in 2015, aiming to reduce rates in children by 5% by 2025.

In 2014 a Coroner’s Report following the death of a 10-year-old boy resulting from complications associated with his obesity recommended the establishment of a local weight management service at John Hunter Children’s Hospital.

Aim Statement

By January 2019, 100% children and adolescents with severe obesity when seen by the Paediatric Weight Management Service at John Hunter Children’s Hospital will adopt two or more healthy lifestyle behaviours.

Team members

Sponsor (Guidance team) members:
• Prof. Trish Davidson – Executive Director Children, Young People & Families, HNELHD

Project team members:
• Cathy Grahame, Dr Liz Percival, Dr Krista Monkhouse, Dr Kate Bryan, Jared Allen, Kate A’Beckett, Denise Wong, Sue, Meredith Jordan, Carolyn Matthews, Loukas Nadiotis, Anne McCre

Quality Advisor:
• Mathew Frith – Network Manager, CYPFS

Patient / consumer involvement:
• Jenny Richards (parent)

Alignment with National Standards

• Standard 1: 1 – Knowledge and awareness of the National Standards
• Standard 2: 2 – Partnering with Consumers
• Standard 3 – Clinical Framework

Literature Review


PDSA Cycles

<table>
<thead>
<tr>
<th>Change Idea</th>
<th>Name of Change Idea to look at in a PDSA Cycle</th>
<th>Staff to co-ordinate PDSA</th>
<th>Measures: How will you know that the change is an improvement?</th>
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</thead>
<tbody>
<tr>
<td>Priority 1</td>
<td>Increase knowledge and understanding of NICE guidelines and management of obesity in children</td>
<td>Kate A’Beckett, Liz Percival, Trish Davidson</td>
<td>% Patients in PDSA with documented BMI for age and obesity severity plotted on growth chart</td>
</tr>
<tr>
<td>Priority 2</td>
<td>Increase knowledge and understanding of NICE guidelines and management of obesity in children</td>
<td>Kate A’Beckett, Liz Percival, Trish Davidson</td>
<td>% Patients in PDSA with documented BMI for age and obesity severity plotted on growth chart</td>
</tr>
<tr>
<td>Priority 3</td>
<td>Increase knowledge and understanding of NICE guidelines and management of obesity in children</td>
<td>Jared Allen</td>
<td>% Patients in PDSA with documented BMI for age and obesity severity plotted on growth chart</td>
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<tr>
<td>Priority 4</td>
<td>Increase knowledge and understanding of NICE guidelines and management of obesity in children</td>
<td>Jared Allen</td>
<td>% Patients in PDSA with documented BMI for age and obesity severity plotted on growth chart</td>
</tr>
<tr>
<td>Priority 5</td>
<td>Increase knowledge and understanding of NICE guidelines and management of obesity in children</td>
<td>Jared Allen</td>
<td>% Patients in PDSA with documented BMI for age and obesity severity plotted on growth chart</td>
</tr>
<tr>
<td>Priority 6</td>
<td>Increase knowledge and understanding of NICE guidelines and management of obesity in children</td>
<td>Jared Allen</td>
<td>% Patients in PDSA with documented BMI for age and obesity severity plotted on growth chart</td>
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</tbody>
</table>

Overall Outcome of Project

100% children and adolescents with severe obesity seen by the Paediatric Weight Management Service have adopted 2 or more healthy lifestyle behaviours.

Sustainability

Initiatives have been standardised and embedded within service systems.

Potential sustainability risks identified and action plans developed in relation to infrastructure and monitoring.

Strategies for Spreading / Sharing

The next step is to investigate how to adapt the service to better support rural families and sustain long-term follow-up.
Aim Statement:
Within 6 months, 40% of women attending Tweed and Murwillumbah Antenatal Clinics will accept referrals to Get Healthy in Pregnancy for information and coaching on healthy lifestyle choices to prevent excessive weight gain in pregnancy.

A problem worth solving:
Overweight and Obesity and Excessive Gestational Weight Gain are key risk factors for stillbirth and a number of serious medical problems for mother and baby.

Women with EGWG stay on average 20% longer in hospital. This translates to an extra day in hospital for every 1kg increase in maternal weight gain. In addition, excess weight gain can translate to an extra day in hospital for every 1kg increase in maternal weight gain. This is important because these factors contribute to many serious medical problems for the mother and baby.

Link to National Standard (NSQHs):
5. Comprehensive care
5.4 The health service organisation has systems for comprehensive care that:
• Support clinicians to develop and communicate comprehensive plans for patients’ care and treatment
• Provide care to patients in the setting that best meets their clinical needs
• Ensure timely referral of patients with specialist healthcare needs to relevant services

Literature review:
[1] Maternal pre-pregnancy obesity and excess pregnancy weight gain (EGWG) are key risk factors for stillbirth and a number of serious medical problems for mother and baby. Women with EGWG stay on average 20% longer in hospital. This translates to an extra day in hospital for every 1kg increase in maternal weight gain. In addition, excess weight gain can translate to an extra day in hospital for every 1kg increase in maternal weight gain. This is important because these factors contribute to many serious medical problems for the mother and baby.

Results

Outcome measures: pre (March) and post (April – Nov) intervention.

Discussion:
The outcome measure is the proportion of referrals accepted by women and sent to GHIP service by email or fax. Numerator = number of referrals received by GHIP service for that month. Denominator = total number of births at that facility in 2016 for that month. The intervention (blue) line is the proportion in Murwillumbah and Tweed Hospitals. The control (green) line is the other maternity hospitals and clinics in NNSWLHD. The pink line is the Key Performance Indicator in the NNSWLHD Service Agreement.

Process Measures:
Most PDSAs were implemented in the first few months of the project. Antenatal clinics now report routinely offering referral to GHIP to all women however the recent dip in the number of referrals received by the Ministry of Health from Tweed Hospital needs investigating.

Balancing Measures:
Initially, there was a problem of Queensland residents who were referred to the program not being counted as referrals even though they were referred from a NSW Hospital and received the service. This was the balancing measure but was corrected by July 2018.

Overall Outcome of Project:
The aim of having 40% of pregnant women referred to GHIP within 6 months was achieved (42% at 6 months – October, 2018) but the drop in November needs to be investigated and efforts need to be sustained to maintain referral to GHIP becomes routine service. Since the intervention, 256 women have received advice and coaching support for healthy weight gain in pregnancy in the target site compared to 62 in control sites.

Plans to sustain change:
Standardisation: a) Asking Maternity Staff how we can help them implement any new policy will be a standard approach from now on, and b) Routine offer of referral to GHIP for all pregnant women across the LHD

Monitoring and documenting: Referrals will continue to be monitored and reported as this is a KPI in the service agreement

Training: 12 Health Promotion Officers have been trained in Improvement Science approach.

Plans to spread/share change:
The project will be rolled out to other hospitals in the LHD and has been shared with two other LHDs at their request. It will also be shared on the ACI Information Exchange and submitted for a Quality Award with NNSWLHD in 2019.
Aim Statement

Within 12 months pre-faints and faints onsite post donation at 8 Blood Donor Collection Centres will be reduced by 5-15% incidence and result in 0% injuries to donors.

Driver Diagram

- PDSA 3 - Change Concept
- EMPOWER Pareto Charts
- EMPOWER Results

STRATEGIC PILLARS

- Reducing pre faints and faints in blood donors is essential if the Blood Service is to meet its At the Leading Edge strategic pillars which include expanding our donor panel and service excellence this will enable us to continue to supply safe, high quality products and services in line with demand, that meet demand.

ACKNOWLEDGEMENTS

I would like to acknowledge the generosity of Sarah Turnbull and her boys Nick and Moll in sharing their story. Thank you to all the EMPOWER Collection Centres for participating in this initiative and for the daily care of our amazing volunteer donors.

Australian governments fund the Australian Red Cross Blood Service to provide blood, blood products and services to the Australian community.
Enhancing Nutrition Care on a Medical Ward

Project Statement:
- By December 2018, 50% of inpatients with a diagnosis of Chronic Obstructive Pulmonary Disease at Mudgee Hospital will have access to dietician consultation.
- Stretch goal: 50% - Up from 5%.
- Managing within current resources.

Background to Problem Worth Solving
- AOM FY16-17 data: 240 COPD inpatients seen by Dietitian.
- Mudgee: Population 24,000.
- 8 hours per week public Community Dietitian.
- NH Hospital Dietitian.
- Limited access to private Dietitians.

National Standards: 5 Comprehensive Care

Literature review
- Nutrition Care for Older People (2016).

Nutrition Care
- Improved nutrition - Better patient outcomes.
- 30% reduction in average length of stay.
- 40% reduction in readmissions.

Team members
- Catherine Liberti, Lauren Bond, C10x50x, Dietitians.
- Jenny Bryant - RN Chronic Disease Coordinator.
- Sharon Fagan - EN Intake Worker.
- Maree Nott - Costing Manager - Mudgee.
- Callie McMahon - Clinical Nutrition Advisor.
- Jenny Boytov - CNO Leading Value Care.
- Quality Advisor - Karen Smith.

Patient/consumer involvement: COPD patients on ward and Community clients.

Primary Drivers
- EFT of allied health workforce at Mudgee.
- Create referral pathways for dietician services.
- Education for staff on documentation required for coding.

Secondary Drivers
- Identify patients with COPD on admission to ward.
- Monthly review of COPD patients on ward by Dietitian.
- Staff trained to screen for nutrition risk.
- Staff trained to order and follow-up on food and nutrition orders.
- Staff trained to follow-up on nutrition plans.
- Staff trained in nutrition advice.

Change Ideas
- Identify patients at risk of poor nutrition through MHT.
- Implement MHT to audit nutrition.
- Identify risk & referral pathways for Dietitians.
- Empower Dietitians to serve ward.
- Review MHT processes and membership format.
- Provide managers with education on calculating funding allocated to MHT.
- Implement integrated management.

Priority Change Ideas
- Impact: Low Implementation: Easy.

Testing a Change idea via a PDSA Cycle:
- PDSA cycle 1.0: MHT audit.
- PDSA cycle 1.5: MHT review.
- PDSA cycle 2.0: MHT training.

Overall Outcome of Project:
- Aim: 50% of inpatients with a diagnosis of COPD have access to dietician consultation.
- Stretch goal: 50% - met.
- Cost saving.
- 55 patients with COPD.
- ALOS 4.69 days = 272 Bed Days.
- Av cost per encounter $4480.
- Total cost $259,834.
- Potential Savings @ 25% (14 patients) = $11,970.
- Potential Savings @ 25% (14 patients) = $25,938.
- Potential savings: NUTRIENT identified $4985.5 per encounter @ 25% = $64,147.75 pa.

Results
- Process measures.
- Balancing measures.
- Discussion.

Plan to sustain change:
- Embed nutrition in normal practice.
- Quarterly quality review.
- \50% of all Dietets: Inpatient referral rates not seen.
- More Dietets: Hospitalised.
- Documentation of MHT.
- Education.
- Private Practice.

Learnings and Plans to spread change:
- It takes time to foster team collaboration.
- Knowledge translation: involves educating those to be shared.
- A champion is vital to maintain the focus.
- Keep motivated with small changes and early results.
- Look broadly for resources.
- To other AHD disciplines.
- To other environments.

Activity: VNSW/LHD Health Innovation Awards.
**Automated Hepatitis Results in 24hrs**

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ECLP Cohort

**Aim Statement:**  
By December 2018, the turnaround time for 100% of the high volume automated Hepatitis testing at the Westmead laboratory will be <24 hours.

**Background to problem worth solving:**  
Hepatitis is a public health concern, infecting tens of thousands of NSW residents. Hepatitis B is vaccine preventable, and Hepatitis C is >95% curable. The lab tests take minutes to perform however turnaround time is measured in days. Infected patients from low compliance groups (e.g. intravenous drug users) are at risk of being lost to the system and not receiving treatment in this time.

**Team members:**  
- **Sponsor:**  
  Prof Sharon Chen (Clinical Director Microbiology)  
- **Project Team:**  
  - Team Leader – Dr Linda Huxton (Serology)  
  - Team – Dr Josh Ryan (Chemical Pathologist), Anna, Yvonne, Parul, Helena (Serology), Carmel, Danny, Chinnelle, Melanie (Chemistry), Dave (Specimen Reception)  
  - Consumer – Dr Matthew O’Sullivan (Microbiologist)

**Link to Strategic Imperatives:**  
- NSW Hepatitis B Strategy 2014 – 2020  
- NSW Hepatitis C Strategy 2014-2020  

**Driver Diagram**

**The Problem:**  
The turnaround time for automated Hepatitis testing is too long and inconsistent, impacting customer expectations and patient experience.

**SMART Aim:**  
By December 2018, the TAT for 100% of automated Hepatitis testing at ICPLM will be <24 hours.

**Team Members:**  
- **Project Sponsor:**  Sharon Chen  
  - Team Leader – Dr Linda Huxton  
  - Consumer – Matthew O’Sullivan  
  - Serology (Anna, Yvonne, Parul, Helena)  
  - Chemical Pathology (Carmel, Danny, Chinnelle, Melanie, Dave)  
  - IT (Tami, Tony, Charlie)

**Overall Outcome of Project:**  
The focus on improving Hepatitis testing turnaround time has delivered 12 months of continuous improvement, achieving the desired outcome of 100% of Hepatitis testing being completed within 24 hours. Clinical expectations are met and managed, and the management of infected patients is more effective because they remain connected with the service.

**$ Cost saving**  
1 FTE Scientist position was not replaced as a result of the project, delivering recurrent savings of ~$100,000 per annum. The savings net of the costs incurred for the refurbished instrument are $72,580 per annum.

**Plans to sustain change:**  
- The Hepatitis ordering decision support tool has been implemented into Powerchart.  
- The management of the Serology instrument has been transferred to the core lab.  
- Procedure documentation for performing Hepatitis testing allowed testing to take place as samples arrived in the lab, instead of in batches aligned with the day shift roster.  
  - This roster progressed to include weekend coverage, and that drove total turnaround time below the target 24 hours (saved 6 hours).

**Will we eliminate Hepatitis in my lifetime?**  
This project supports the ambitious goal of the elimination of Hepatitis from the community by 2028. PBS listed direct acting antiviral drugs, increased screening of pregnant women, and childhood vaccination rates above 95% are strategies employed to achieve this goal today. This strategy is supported by an efficient laboratory screening service, confirmatory testing, viral loads, and resistance testing.  
I’d like to acknowledge the expert laboratory teams that are working towards this goal, and whose success on this project is a small step towards eliminating Hepatitis B and C.
Reducing Surgical Site Infection Rate after Caesarean Sections

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ECLP Cohort 20

Aim Statement: Within 12 months, 50% reduction in Surgical Site Infection Rate for Patients after Caesarean Sections.

Background: At Tamworth Regional Referral Hospital (TRRH) in December 2016, 5 surgical site infection (SSIs) in caesarean sections (CS) were identified, with 4 of those in women with BMI>40. Furthermore, a rate of 2.7% of SSIs for the first half of 2017 was identified in CSs done at TRRH compared to 1% Nationally.

Common variations in care and gaps in best evidence care delivery across the care continuum treatment as follows:
• The majority of women who acquired a post operative wound infections had a BMI >35.
• A providone-iodine solution was used as a preoperative skin preparation.
• Antibiotic prophylaxis was not routinely given within therapeutic timeframe and poorly documented.
• All women were given standard surgical dressings and post operative care, despite some having recognised risk factors such as obesity and diabetes.

Figure 1: Surgical site infection post caesarean section

A local clinical audit was completed on all women presenting with a SSI post CS based on The World Health Organisation Global Guidelines for the prevention of SSIs (2016). 

Objective: Aim for sustainable improvement.

Plan: Repeated training sessions. The permanent team will educate new and locum doctors about the bundled intervention strategy to reduce SSIs.

We have encountered difficulties with implementation of each aspect of the bundle. Weekly discussions and multiple strategies to overcome obstacles (and PDSAs) took place.

Overall Outcome of Project:
• Our stretch goal was to achieve a 50% reduction in surgical site infection rate for patients after caesarean sections within 12 months.
• As the result of the implementation of the bundled interventions strategy the overall rate of infection dropped from 5.1% in 2017 to 1.7% in 2018, effectively reducing the infection rate by 67% and thereby fulfilling the stretch goal.

$ Cost saving
• Cost savings are estimated between USD 7,003 for superficial and USD 25,721 for deep infections.


Plans to sustain change:
• Train new staff (nurses, midwives, anaesthetists, Obstetricians) about the Bundle approach.
• Random audits of the bundle.
• Review of patient journey for each infection, report to morbidity and Mortality meetings, and feed back to staff.

Plans to spread and share change:
• We have applied for Translational Research Grant (TRG), which will enable to replicate the bundled strategy for four other maternity units in NSW.
• We are sharing the bundle results with our local clinical and registries on secondment, aiming for them to spread the change as well.
• I am presenting to the Anaesthetic department, to the Medical Staff Council, and others.
### Engaging Fathers in Parenting Programs

**By December 2018, 100% of dads who were registered and attended “Hello Dad: Dads Matter” had improved access to a structured and evidence-based parenting program within Tresillian.**

**Background:**

1) Dads are left holding the baby when mums experience postnatal depression/ anxiety or at risk of self-harm 2) Rate of depression in new dads is 10% 3) No Perinatal Screening for dads

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**Driver Diagram**

**The Problem:**

- Fathers have limited access to evidence-based parenting programs in the first 12 months following the birth of a child within SHDO

**By December 2018, registered fathers will have improved access to evidence-based parenting programs within Tresillian.**

**Primary Drivers**

- Referral Rate
- Attendance Rate
- Drop Out Rate
- Improved Level of Knowledge

**Secondary Drivers**

- No parenting services for fathers
- GPs do not have time to provide psychosocial interventions
- Fathers working the week and need access
- Fathers are important in the parenting relationship
- Mums have a lot of input but not fathers
- If fathers attend, it will impact positively on clinical outcomes
- Fathers do not attend programs
- Fathers do not like interventions
- Fathers prefer one-off programs
- 1 in 10 fathers are known to experience depression
- Improved clinical input will improve parental relationships
- Evidence of reduced child protection risk

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**Change Ideas**

- Start small at TFCO first
- Ask fathers what they want first
- Do in hospitals
- Target matenery
- Services for dads should be core business
- Fathers’ input has a big impact on their care relationship
- Initiatives for fathers do not have good results
- GPs don’t go even to GF
- Target antenatal
- Try engaging programs
- Fathers like workshops
- Fathers prefer talks, not face-to-face
- Evidence of improved clinical outcomes
- Data records improved father involvement result in positive outcome
- Opportunistic programs may identify health & activate referrals ads

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**Overall Outcome of Project:** 100% of dads who were registered and attended the program had improved access to a structured and evidence-based program:

- Improvement in numbers by Group 6
- Consistently positive feedback on Self-Report Scale
- Opportunistic Mental Health Assessments of dads
- Positive Clinical Outcomes

**Plans to sustain change:**

- Tresillian CE will be meeting with Prof Fletcher to discuss SMS4Dads & father-inclusive practices
- Maintain discussion at senior level to promote father-inclusive practices
- Standardisation of Group Program within Tresillian
- Partnering with Ashfield Infants Home in delivering the program
- Documentation & presentation

**Plans to spread / share change:**

- Further integration of father-inclusive practices
- Explore concept of perinatal screening for dads
- Work towards changing the narrative about men & dads

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**Number of dads**

**Self-Report Scale**

**Change Concept 1 - PDSA Cycle**

1. **PLAN YOUR CHANGE**
   - Discard original Project Aim
   - Re-design “scaled back” Project
   - Research Dads Groups
   - Establish Need
   - Partner with Creating Links (Hazel)
   - Recruit, referrals, program design
   - Data: Number of referrals; Number of participants

2. **CARRY OUT YOUR CHANGE AND OBSERVE AND MEASURE**
   - Facilitate Group Program
   - Review data & feedback
   - Monitor & Graph
   - Recommendation from dads shaped future Groups, fine-tuning co-design model
   - Monitor results
   - Trial different setting to improve data

3. **ACT ON THE DATA**
   - Partnered with Ashfield Infant’s Home
   - Much improved results
   - Review data
   - Review feedback
   - Discussion with Ashfield Infant’s Home to explore future groups