



QUALITY
IMPROVEMENT
AWARDS

QUALITY INITIATIVES

The 23rd Annual
ACHS Quality Improvement
Awards 2020

Quality Initiatives – Entries in the 23rd Annual ACHS Quality Improvement Awards 2020.

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Introduction

The 23rd Annual ACHS Quality Improvement Awards 2020

The annual ACHS Quality Improvement (QI) Awards were introduced in 1997 to acknowledge and encourage outstanding quality improvement activities, programs or strategies that have been implemented in healthcare organisations.

In 2020, the 23rd Annual ACHS QI Awards were open to submissions from all domestic ACHS and international ACHSI member organisations following the ACHS NSQHS (National Safety and Quality Health Service) Standards Program, EQuIP6 (Evaluation and Quality Improvement Program), Standards Program, EQuIP6 Day Procedure Centres, EQuIP6 Oral Health Services, EQuIP6 Haemodialysis Centres, EQuIP6 Aged Care Services, EQuIP6 Healthcare Support Services, and the ACHS Clinical Indicator Program.

Judging was conducted externally with separate panels of three judges for each of the QI Awards categories:

Clinical Excellence and Patient Safety: This category recognises innovation and demonstrated quality improvement in the delivery of safe, effective patient care.

Non-Clinical Service Delivery: This category acknowledges a demonstrated outcome of improvement and innovation in patient and/or consumer services and organisation-wide practice including services provided by community and allied health organisations.

Healthcare Measurement: This category recognises organisations that have measured an aspect of clinical management and/or outcome of care, taken appropriate action in response to that measurement, and demonstrated improved patient care and organisational performance upon further measurement. Healthcare measurement can include data collected from the ACHS Clinical Indicator program or other methods of monitoring patient care processes or outcomes. Both quantitative and qualitative data can be used, however this category must describe the initial measurement, the analysis of that measurement, the action(s) implemented, and the improved measurement(s).

Global Quality Improvement Award: The Global Quality Improvement Award recognises organisations that are using Australian healthcare standards to strengthen quality improvement frameworks internationally. ACHS has recognised the implementation of Australian healthcare standards internationally for many years, previously awarding Highly Commended Certificates.

The Global Quality Improvement Award is selected from all of the Submissions received by ACHS.

Each judging panel consisted of an ACHS Councillor, an ACHS surveyor and a representative from an ACHS member organisation.

Submissions were required to meet specific criteria that were weighted equally:

- Judges assessed all eligible submissions on the five (5) ACHS principles of: consumer focus, effective leadership, continuous improvement, evidence of outcomes and best practice;
- Judges assessed additional criteria: improvement in patient safety and care, measured outcomes, applicability in other settings, innovation in patient care and/or processes and relevance to the QI Awards category;
- The submission MUST relate to a period of up to no more than two (2) years prior to the year of entry.

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

ACHS publishes submissions from all participating organisations to share and encourage exceptional quality improvement strategies amongst the ACHS member organisations.

The electronic version of this document will be published on the ACHS website (www.achs.org.au).



Winner Submissions by Category

The 23rd Annual ACHS Quality Improvement Awards 2020

CLINICAL EXCELLENCE AND PATIENT SAFETY

Victorian Institute of Forensic Mental Health (Forensicare), VIC

Thomas Embling Hospital and the Centre for Forensic Behavioural Science

Implementing an electronic instrument and clinical decision support system to predict imminent aggression and structure intervention to reduce aggression and the use of restrictive interventions

Tessa Maguire, Jessica Griffiths, Michael Daffern, James Ogloff, Brian McKenna, Chris Guest and Jo Ryan

Full submission page 5

NON-CLINICAL SERVICE DELIVERY

Redcliffe Hospital, QLD

Pharmacy Department

Drive Through Pharmacy Collections – Minimising hospital visits for vulnerable patients

Michael Spargo, Ann Whitaker, Geoffrey Grima and Alysha Hoogendoorn

Full submission page 26

HEALTHCARE MEASUREMENT

Metro North Hospital and Health Service, QLD

Clinical Governance, Safety, Quality and Risk

Using Hospital Acquired Complication Data to Improve Patient Outcomes

Mark Butterworth, Craig Draper, Nicole Pearson, Michelle Marshman and Sarah Cake

Full submission page 40

GLOBAL QUALITY IMPROVEMENT

Hong Kong University Shenzhen Hospital, China

Medical Imaging Centre

Reduction of Door to Wire time for patients with ST-elevation Myocardial Infarction to improve clinical outcomes

Hu Xiao Ming, Yiu Kai Hang, Chen Bo, Wu Min, Chen Hong Da, Wang Run and Cao Gao Zhen

Full submission page 52



Highly Commended Submissions by Category

The 23rd Annual ACHS Quality Improvement Awards 2020

CLINICAL EXCELLENCE AND PATIENT SAFETY

North Metropolitan Health Service, WA

Mental Health, Public Health and Dental Services

North Metropolitan Health Service Smoke Free Mental Health Project

Heather Monteiro, Krista Coward, Joanna Fagan, Viki Pascu and Michael Sitas

Summary Abstract page 15

Sydney Local Health District, NSW

RPA Virtual Hospital

rpavirtual – a new way of caring

Freya Raffan, Miranda Shaw, Dianna Jagers, Owen Hutchings and Cassandra Dearing

Summary Abstract page 17

WA Country Health Service, WA

Geraldton Hospital

SAFER TOOL PROJECT – Partnering with consumers to improve outcomes and minimise risk of falling and pressure injuries

Narelle Dennett, Karen Zayco, Liza Doble, Kirra Pallant and Shannon Mcaullay

Summary Abstract page 18

NON-CLINICAL SERVICE DELIVERY

Western Sydney Local Health District, NSW

Auburn Hospital

Just Ask It!

Sally Henderson, Kristy Kendrigan, Riki Richards, Narelle Holden, Debbie Sharpe, Lidiya Malinov and Tanja Nietlisbach

Summary Abstract page 33

Uniting War Memorial Hospital, NSW

Allied Health and Integrated Care

Wellness checks at War Memorial Hospital – connecting with our clients to prevent avoidable hospital admission and deterioration during COVID-19

Genevieve Maiden, Wendy Longley, Annabel Kingsford, Rachel Kingma, Julie Manger, Michael Fitzpatrick, Jill Hall and Lynda Elias

Summary Abstract page 34

Royal Perth Bentley Group – East Metropolitan Health Service, WA

Social Work Department

Mental Health Homeless Pathways Project (MHPP)

Kat Ahlers and Carla Francis

Summary Abstract page 36



HEALTHCARE MEASUREMENT

Bolton Clarke, QLD

Care, Innovation and Quality team

Developing Clinical Outcome Indicators applicable to a home nursing environment

Janet Pugh and Tracy Aylen

Summary Abstract page 47

Townsville Hospital and Health Service, QLD

Healthcare Standards

Sustained reduction in Wrong Blood in Tube incidents at Townsville University Hospital

Natalie Shiells, John Casey, Neil Silvester and Jody Gallagher

Summary Abstract page 48

GLOBAL QUALITY IMPROVEMENT

Hong Kong University Shenzhen Hospital, China

Clinical Oncology Centre

Advocacy to provide good quality oncology services during the COVID-19 pandemic

A.W.M. Lee, Xu Zhiyuan, Hui Siu Kee Tim and Dong Fule

Summary Abstract page 59

Hong Kong University Shenzhen Hospital, China

Department of Nursing, General Medicine Ward

Multidisciplinary Team Approach to Reduce the Incident Rate of Fall in Medical Ward

Lan Ping Shi, Yan Zhi Yi, Jian Fen Cao, Pei Shan Li, Chun Hong Liu, Li Qiong Zhou, Shan Shan He, Qiu Li Chen

Summary Abstract page 59

Hong Kong Baptist Hospital, Hong Kong SAR

Nursing Administration Office

Multidisciplinary Fall Prevention Strategies to Reduce Falls in hospital

Li Yuen Man Hilda, To Ka Wing, Cheung Ching Yee Cindy, Cheung Kim Keung Dennis, Yuen Wing Sze Jammie, Wong Oi,

Lan Ellen and Lee Wai Yee Susanna

Summary Abstract page 60

International Medical Centre, Kingdom of Saudi Arabia

Pharmacy Department

Waiting Time of Out Patient Pharmacy

Ali Saber, Basmah AlQumysh, Jamal Siddiqi and Reham Salem

Summary Abstract page 61

Royal Bahrain Hospital, Kingdom of Bahrain

Infection Control and Quality

COVID 19 Prevention and Control Strategies

Anal Thankappan, Tariq Almusawi and Rehana Nazir

Summary Abstract page 62



CLINICAL EXCELLENCE AND PATIENT SAFETY

WINNER

Victorian Institute of Forensic Mental Health (Forensicare), VIC

Thomas Embling Hospital and the Centre for Forensic Behavioural Science

Implementing an electronic instrument and clinical decision support system to predict imminent aggression and structure intervention to reduce aggression and the use of restrictive interventions

Tessa Maquire, Jessica Griffiths, Michael Daffern, James Ogloff, Brian McKenna, Chris Guest and Jo Ryan

AIM

This project aimed to test the incorporation of a validated instrument for the prediction of imminent aggression (the Dynamic Appraisal of Situational Aggression, DASA) alongside an Aggression Prevention Protocol (APP) into an electronic Clinical Decision Support System (CDSS) to improve prevention of aggression in two acute male forensic mental health units. It was hypothesised that implementation and use of the CDSS would be both feasible and acceptable, and significantly reduce restrictive interventions and aggression.

SUMMARY ABSTRACT

In 2013/14 a survey of 411 Victorian mental health staff found that 34% reported being victims of past year physical violence. Violence and aggression directed towards co-patients and staff, is unfortunately a far too common occurrence. For patients, being a victim of aggression can be traumatising and reduce perceptions of hospital as a safe and therapeutic space. For staff, being a victim of aggression can result in psychological and physical injury and impact capacity to therapeutically engage with patients. Improving healthcare environments and practices to better identify and prevent the causes of violence and aggression and reduce, and where possible eliminate restrictive interventions is a Victorian Government priority.

Thomas Embling Hospital (TEH), the inpatient forensic mental health service for Victoria, has a focus on improving policies, practice, staff development and structuring the environment to better prevent violent and aggressive behaviour, while minimising the need for restrictive interventions, which include seclusion and restraint. Research conducted with consumers in TEH has identified that factors such as personality dysfunction and coping difficulty, substance abuse, cognitive impairment and beliefs about the acceptability of antisocial behaviour are highly prevalent and contribute to high risk of inpatient aggression.

To counter this, research has been conducted to understand the causes of and indicators of imminent inpatient aggression. The Dynamic Appraisal of Situational Aggression (DASA) is a 7-item clinician-rated instrument that assesses risk for imminent aggression based on the presence of factors such as irritability and impulsivity in the previous 24 hours. It has been shown to be feasible for daily use and accurate in predicting imminent aggression. A project conducted in 2017/2018 examined how commonly utilised nursing interventions corresponded with DASA risk levels, and how they were effective in preventing aggression escalation. This research underpinned the development of the APP, a structured guide for nursing intervention tailored to the severity, imminence and causes of escalating or actual aggression. The APP is designed to prompt early intervention, and prioritise the use of the least restrictive interventions

After identifying a need to automate DASA and APP to embed into routine practice, the Forensicare Information and Communications Technology Strategic Manager developed an electronic Clinical Decision Support System (CDSS) that integrated the eDASA+APP into the electronic medical record system. After piloting the eDASA+APP on the female acute unit in 2017/18, a prospective randomised controlled trial (RCT) with a cross-over design was conducted in 2019 on two male acute inpatient forensic mental health units.

This quality improvement nomination is for the robust, intradisciplinary research and health systems development that led the CDSS in the form of the eDASA+APP being trialed via the RCT cross-over study on both male units. Research project findings and the broader impact and use of the developed instruments and practice resources, support this as a substantial quality improvement initiative within a high complexity healthcare setting. Importantly, an experimental research method demonstrated the capacity of the CDSS to significantly enhance the use of preventative interventions while significantly reducing the use of seclusion, physical and mechanical restraint, and pro-re-nata (PRN) medication, while also increasing documentation.



In 2019, the RCT was used to evaluate the implementation of the CDSS initially on one unit, with a 2-week training phase to prepare staff for eDASA+APP use and an 8-week intervention phase. After a 2-month washout, the APP was ceased and a 2-week training phase commenced on the second unit. Collected data showed that relative to baseline, there was a significant reduction with the eDASA+APP in seclusion (from 22.3 to 16.2 seclusion episodes per 1000 occupied bed days) and PRN medication use (36% reduction), significant increase in de-escalation interventions (50% increase in talkdown, 305% increase in reassurance, and 241% increase in distraction techniques) and a 43% reduction in aggression. The strong findings of improved practice and safety achieved with robust implementation of the CDSS has supported implementation of the electronic form of the eDASA in all acute inpatient units of TEH. Our staff have also supported other national and international mental health hospital services in implementing the DASA and the DASA:YV (a youth version of the DASA) as a brief, sensitive and accurate instrument for imminent aggression prediction and prevention. This highlights the significant achievement we have had locally and internationally through this program of consumer- and staff-inspired work to improve staff practice and capability in making hospitals a safer place for all.

REPORT

APPLICATION OF ACHS PRINCIPLES

1. Consumer Focus

Research that has involved asking consumers about their perspectives on the therapeutic value of psychiatric environments has highlighted the critical importance of these settings being perceived as safe and a place where they can access relief from illness symptoms and support that fosters hope and opportunities to work towards illness, personal and functional recovery (Donald et al., 2015). Unfortunately, in many inpatient psychiatry settings, traumatic or potentially harmful experiences are encountered. This could include events that occur prior to (e.g. being handcuffed and transported by police) or during (e.g. witnessing or being a victim of physical or sexual assault or not having adequate privacy for self-care) hospital admission (Frueh et al., 2005). It could also involve aspects of care that may be given involuntarily (e.g. injected sedating medication) or utilise highly restrictive interventions (e.g. physical or mechanical restraint or seclusion) that can further traumatise often vulnerable individuals and impact upon the capacity of health professionals and consumers to form effective therapeutic relationships that underpin effective care (Bowers, 2014).

Forensic mental health inpatient settings may in particular be places in which conflict and perceived threat may be encountered. This commonly interacts with histories of victimisation and abuse to increase the distress experienced among consumers. Persistent mental illness symptoms, attitudes supportive of aggression and offending, difficulty with anger and managing negative emotions and problems with substance use, are also often evident and often contributed to the index offence that led to the forensic hospital admission and delay time in recovery and prolong hospital admission (Ogloff et al., 2015). These factors may contribute to perceived powerless, frustration and reluctance to engage in therapeutic programs, or use of aggressive behaviour to pursue desired goals, potentially resulting in harm to other consumers or staff.

Development and implementation of the electronic Dynamic Appraisal of Situational Aggression + Aggression Prevention Protocol (eDASA+APP) within the acute units of Thomas Embling Hospital (TEH) the Victorian statewide forensic mental health hospital, was directly responsive to requests from consumer advisory and staff advisory groups to improve "SAFETY FOR ALL" through better identifying and guiding staff in the use of early intervention techniques (e.g. distraction, reassurance, talkdown) that address the causes of consumer distress and anger to better prevent aggression occurring (Maguire et al., 2018).

2. Effective Leadership

Development, piloting, embedding into routine care, and ongoing refinement of practice associated with the eDASA+APP has been underpinned by effective and collaborative leadership. Professors Michael Daffern and James Ogloff who led the development of the DASA (Ogloff & Daffern, 2006), hold clinical and academic leadership roles with Swinburne University of Technology and Forensicare, institutions who have effectively partnered in the design, testing and embedding of the sustained use of the eDASA+APP. Collaborative governance has been provided through key staff in clinical, workforce development and research roles meeting regularly to monitor progress, review existing data or propose new projects or innovation, to ensure continual improvement in functionality of the components and overall eDASA+APP clinician decision support system (CDSS). Dr Tessa Maguire, a forensic mental health nursing academic is also represented on Forensicare's Clinical Risk Assessment and Management committee providing a forum to ensure innovation and methods to best prepare and build staff confidence and expertise in using the CDSS and associated aggression prevention interventions are continually reviewed and refined.

3. Continuous Improvement

As shown in Appendix 1, development, piloting and broader roll-out of the eDASA+APP has occurred via iterative phases



of research. This has drawn upon Plan-Do-Study-Act (e.g. Knudsen et al., 2019) and experience-based co-design (e.g. Donetto et al., 2015) methods to enquire about and make refinements or develop knowledge and resources based on what eDASA+APP users and consumers have said they want, to continually improve the use and impact of this innovative Clinical Decision Support System (CDSS). Practice innovation was enabled by high-level clinical and organisational leadership involving university (Swinburne University of Technology) and health service (Forensicare) partners. During the development work, health service and research leaders supported and conducted the collection of health, risk and aggression data that demonstrated dynamic indicators of imminent aggression and enabled validation of DASA accuracy and APP relevance and impact at different levels of behavioural acuity. They then allocated resourcing to develop and implement an electronic data collection and CDSS that was embedded into the service's electronic health record system. This has enabled daily monitoring of dynamic risk and the responses that did or did not prevent aggression occurring.

Two research trials to examine how eDASA+APP performed in different settings (e.g. a female-only unit) and the impact on practice (preventative nursing interventions and medication use), aggression and health service costs were then conducted. This was done to ensure that the eDASA+APP could successfully be embedded into routine practice and sustained improvements in aggression prevention could be achieved, and findings and practice resources shared to support other mental health services struggling to prevent inpatient aggression. New opportunities are currently being pursued to align eDASA data with staffing allocation and critical incident data, so that real time monitoring of acuity, risk and resource allocation can occur. The potential to trial the use of eDASA+APP in prison mental health units operated by Forensicare, highlights the potential to build upon our experience of innovation in practice and prevention, and explore how to best adapt and extend the use of this CDSS in a prison mental health population.

4. Evidence of Outcomes

Two trials have shown the effectiveness of the eDASA+APP as a Clinical Decision Support System (CDSS) to enhance preventative nursing practice and reduce aggression. Appendix 2 provides a brief overview of the study method, and important outcomes found via the 2 conducted trials.

Trial 1: Key findings from an open label study comparing 8-weeks of eDASA only vs 8-weeks of the eDASA+APP on a female only acute unit of a forensic mental health hospital (Maguire et al., 2019).

eDASA (91%) and eDASA+APP (85%) had very high rates of occupied bed days with ratings completed. This highlighted that both were highly acceptable for daily use.

The Intervention Phase in comparison with the Baseline Phase showed:

- Staff prioritised the use of the least restrictive interventions.
- An increase in the use of early intervention nursing techniques such as distraction techniques, one-to-one nursing and reassurance.
- A reduction in the use of seclusion as well as other restrictive interventions such as physical and mechanical restraint and Pro Re Nata (PRN) medication.
- A decrease in incidents of verbal aggression, however, there was no change in other types of aggression.

Nursing staff who had been trained in and utilised the eDASA+APP were also qualitatively asked about the perceptions of whether this should continue to be used in practice. Responses were primarily supportive and included the following:

- I liked all of the interventions available (N1)
- Supports better documentation (N3)
- The protocol suggests how interventions have been effective before and this normally benefits nurses, especially those unfamiliar with the patient (N4)
- The eDASA should continue to be used to further outline our use of risk reducing interventions and evaluation of it (N6)

Trial 2: Key findings from a cluster-randomised trial incorporating a cross-over design with baseline and washout (2-months) periods of implementing for 8-weeks eDASA+APP on two acute units for men of a forensic mental health hospital.

Prior to each eDASA+APP implementation phase, staff were given two 3-hour training sessions to introduce the eDASA+APP and its associated interventions. Hard copy training manuals and posters detailing the eDASA+APP were also placed within the units' staff offices so that staff accessing and utilising this CDSS were regularly educated and supported in its use.

There were high completion rates of both the eDASA and eDASA+APP with a daily rating occurring for 85% of occupied bed days for all phases of the study.

Relative to baseline the experimental phase showed:

- 36% reduction in Pro-re-nata (PRN) medication use.
- 50% increase in talkdown.



- 305% increase in reassurance.
- 241% increase in distraction.
- Seclusion reduced from 22.3 vs 16.2/1000 Occupied Bed Days.
- 43% reduction in aggression incidents.

A cost-effectiveness analysis performed estimated a full-year benefit of \$22,460 (around 3.4 times the initial costs) achieved through reductions in PRN medication use and seclusion incidents that off-set the training and staff backfill costs incurred while implementing the eDASA+APP during the experimental study phases.

5. Striving for Best Practice

The high rates of engagement and use of the eDASA and eDASA+APP during both trials highlight the strong commitment of staff within Forensicare to quality improvement and innovation in practice. The associated reductions in aggression incidents and restrictive intervention use, also highlighted the benefits achieved through the conduct of these studies and the associated system, practice and workforce capability improvements achieved through these collaborative, and impactful projects. The ongoing program of work to refine how staff are supported and trained in their daily use of the eDASA+APP and associated preventative interventions and the service monitors and uses dynamic risk data in clinical review, quality improvement and resource allocation, provides further examples of how Forensicare is continually striving for best practice in working with a highly complex and vulnerable healthcare population.

INNOVATION IN PRACTICE AND PROCESS

The Dynamic Appraisal of Situational Aggression (DASA) is an actuarial assessment instrument to measure the risk of a consumer engaging in aggression or violence in the following 24 hours. It looks at 7 dynamic risk factors: irritability, impulsivity, unwillingness to follow directions, sensitive to provocation, easily angered when requests are denied, negative attitudes and verbal threats. Each factor is scored by a clinician 0 (absent) or 1 (present) in the past 24 hours. A total score of 0 suggests low, 1-3 suggests moderate and 4-7 suggests high risk of acting aggressively in the next 24 hours.

In 2017-18, an electronic version of the DASA was developed by Forensicare's Information and Communication Technology Strategic Manager to enhance capacity to enter, use and record for future quality improvement and research purposes, scoring and responses for individual consumers.

Following analysis of preventative nursing interventions (Limit setting, Medication, 1:1 nursing, Reassurance, Distraction, De-escalation, Observation) used by Forensicare staff in Thomas Embling Hospital with consumers in low,

medium and high DASA bands (Maguire et al., 2018), the Aggression Prevention Protocol was written to reflect the most effective interventions used at each band. In addition to producing a single-paged guiding document (see Figure 2 in Appendix 3), a more detailed Nursing Practice Manual was also published and provided to staff.

A Clinical Decision Support System that connected eDASA ratings with associated APP interventions was then developed and trialled first via an open label study on a female only unit (Maguire et al., 2018), and then via a cluster-randomised controlled trial on 2 males only units (Griffiths et al., under review).

Further development and innovation has since occurred with through refining the manual, guide for staff to rate items, the score sheet and online training. The eDASA is also now being used within prison mental health units operated by Forensicare, and the potential to introduce the combined eDASA+APP as a preventative CDSS within Forensicare's prison mental health units is also being explored.

APPLICABILITY TO OTHER SETTINGS

Through the robust program of development, implementation and quality improvement work conducted to date and ongoing, the DASA, eDASA and eDASA+APP are in use or being pursued for use in many other Victorian, national and international inpatient psychiatry services. Papers have also been published on the use of the DASA as an aggression prediction instrument in hospital emergency departments in the US. This includes DASA implementation in health services in: France (Dumais et al., 2015); the US (Connor et al., 2020); Finland (Lantta et al., 2016); and the United Kingdom (see Appendix 3). Expert recognition of the effectiveness of DASA as an instrument for prediction of imminent aggression was also provided through inclusion of the DASA as a recommended instrument with the 2015 National Institute of Health and Care Excellence (NICE) Guideline on Violence and Aggression.

Further expanding the populations within which the eDASA+APP is used is also being currently pursued. Forensicare is pursuing how the eDASA+APP can best be adapted and implemented within its prison mental health units to broaden preventative approaches in additional forensic mental health settings. The DASA and APP are also being pursued as methods to improve prevention of aggression among residents in aged care settings (Robertson & Daffern, 2020).

The conducted program of quality improvement that has led to the development, refinement and broad embedding of developed instruments and workforce development resources into service practice locally and internationally is

therefore testament to the significant impact of this area of quality improvement, justifying nomination of Forensicare and its partnership with Swinburne University of Technology for an ACHS Quality Improvement award.

REFERENCES

- Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21, 499-508.
- Connor, M., Armbruster, M., Hurley, K., Lee, E., Chen, B. & Doering, L. (In Press). Diagnostic sensitivity of the Dynamic Appraisal of Situational Aggression to predict violence and aggression by behavioral health patients in the emergency department. *Journal of Emergency Nursing*.
- Donald, F., Duff, C., Lee, S., Kroschel, J. & Kulkarni, J. (2015). Consumer perspectives on the therapeutic value of a psychiatric environment. *Journal of Mental Health*, 24(2), 63-67.
- Donetto, S., Pierri, P., Tsianakas V. & Robert, G. (2015). Experience-based co-design and healthcare improvement: Realizing participatory design in the public sector. *The Design Journal*, 18(2), 227-248.
- Dumais, A., Larue, C., Michaud, C. & Goulet M. (2012) Predictive Validity and Psychiatric Nursing Staff's Perception of the Clinical Usefulness of the French Version of the Dynamic Appraisal of Situational Aggression, *Issues in Mental Health Nursing*, 33:10, 670-675.
- Frueh, B.C., Knapp, R.G., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A., Cousins, V.C., Robins, C.S., Monnier, J. & Hiers, T.G. (2005). Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services*, 56(9), 1123-1133.
- Knudsen, S.V., Laursen, H.V.B., Johnsen, S.P., Bartels, P.D., Ehlers, L.H. & Mainz, J. (2019). Can quality improvement improve the quality of care? A systematic review of reported effects and methodological rigor in plan-do-study-act projects. *BMC Health Services Research*, 19, 683.
- Lantta, T., Kontio R., Daffern, M., Adams, C.E. & Valimaki, M. (2016). Using the Dynamic Appraisal of Situational Aggression with mental health inpatients: A feasibility study. *Patient Preference and Adherence*, 10, 691-701.
- Maguire, T., Daffern, M., Bowe, S.J. & McKenna, B. (2019). Evaluating the impact of an electronic application of the Dynamic Appraisal of Situational Aggression with an embedded Aggression Prevention Protocol on aggression and restrictive interventions on a forensic mental health unit. *International Journal of Mental Health Nursing*, 28, 1183-1194.
- Maguire, T., Daffern, M., Bowe, S. & McKenna, B. (2018). Risk assessment and subsequent nursing interventions in a forensic mental health inpatient setting: Associations and impact on aggressive behaviour. *Journal of Clinical Nursing*, 27, e971-e983.
- Ogloff, J.R.P. & Daffern, M. (2006). The Dynamic Appraisal of Situational Aggression: An instrument to assess risk for imminent aggression in psychiatric inpatients. *Behavioral Sciences and the Law*, 24, 799-813.
- Ogloff, J.R.P., Talevski, D., Lemphers, A., Wood, M. & Simmons, M. (2015). Co-occurring mental illness, substance use disorders, and antisocial personality disorder among clients of forensic mental health services. *Psychiatric Rehabilitation Journal*, 38(1), 16-23.
- Robertson, T. & Daffern, M. (2020). Improving the assessment of risk for imminent aggression in older adults in residential facilities. *Aggression and Violent Behavior*, 51, 101364.
- Tonso, M.T., Prematunga, R.K., Norris, S.J., Williams, L., Sands, N. & Elsom, S.J. (2016). Workplace violence in mental health: A Victorian health workforce survey. *International Journal of Mental Health Nursing*, 25, 444-451.



APPENDIX

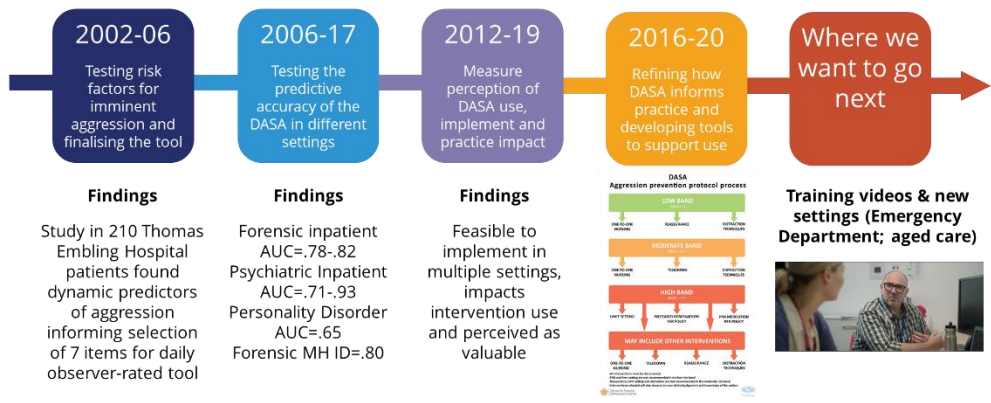
Appendix 1

eDASA+APP: FROM RESEARCH THEORY TO TOOLS IN GLOBAL USE

What the Dynamic Appraisal of Situational Aggression (DASA) addresses:

✓ 17% of psychiatric inpatients engage in violence¹ and 34% of Victorian MH staff were victims of past year physical violence² but prediction of violence is difficult

¹Lozzino et al. (2015) *PLOS One*, 10(6): e0128536; ²Tonso et al. (2016) *IJMHN*, 25(6): 444-451.



Appendix 2: Evidence of Outcomes

Figure 1. Trial 1 study design overview.

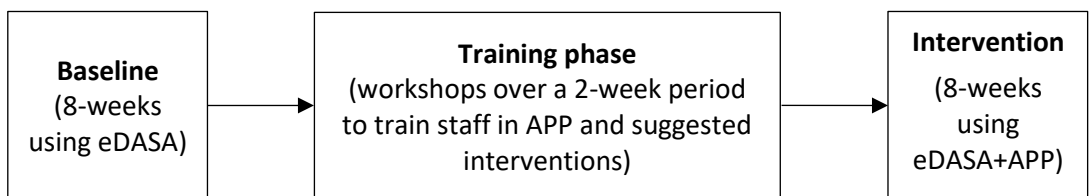


Figure 2. Aggressive incidents occurring across the baseline (Phase 1) and intervention (Phase 2) study periods.

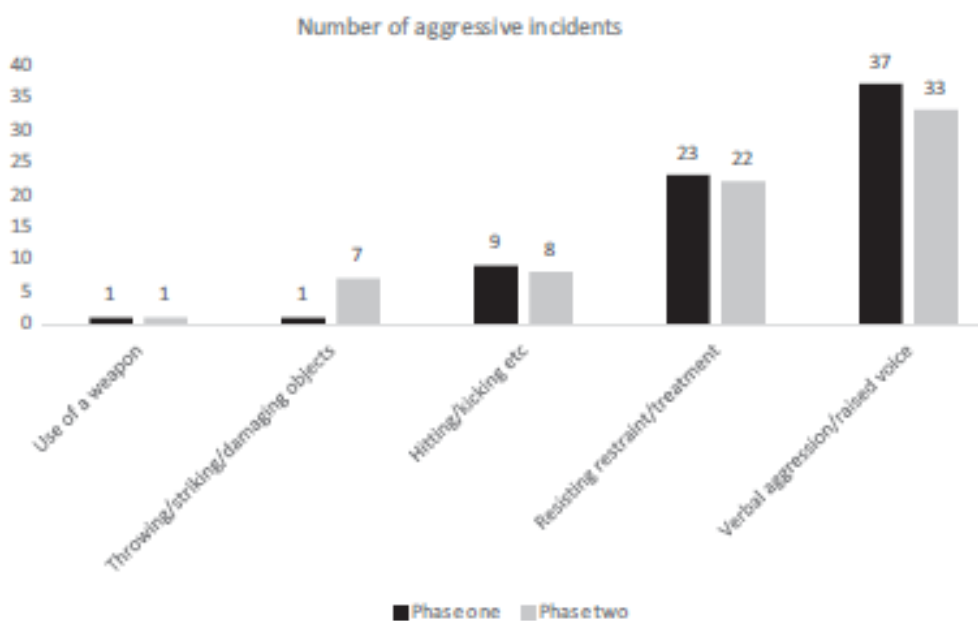


Figure 3. Trial 2 study design overview.

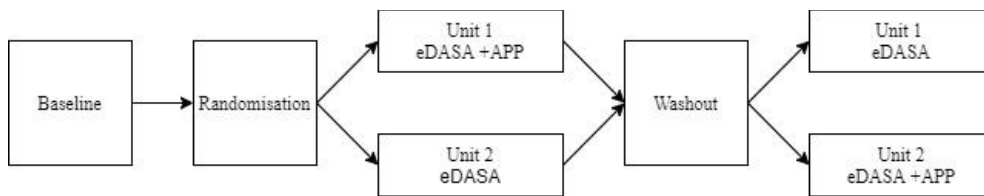


Figure 4. Effect of the eDASA+APP on aggression in the units during the experimental phase (Adjusted Odds Ratios). Note. Mean odds ratios (95% Confidence Interval) of changes during eDASA+APP relative to baseline by type of aggression adjusted for age of the consumer.

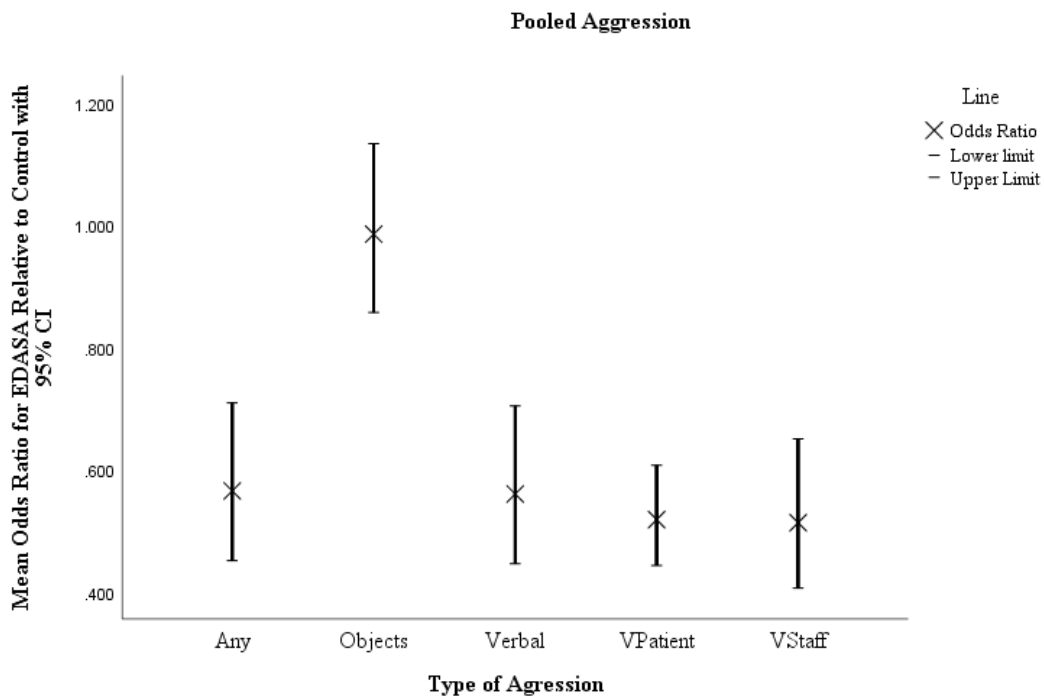
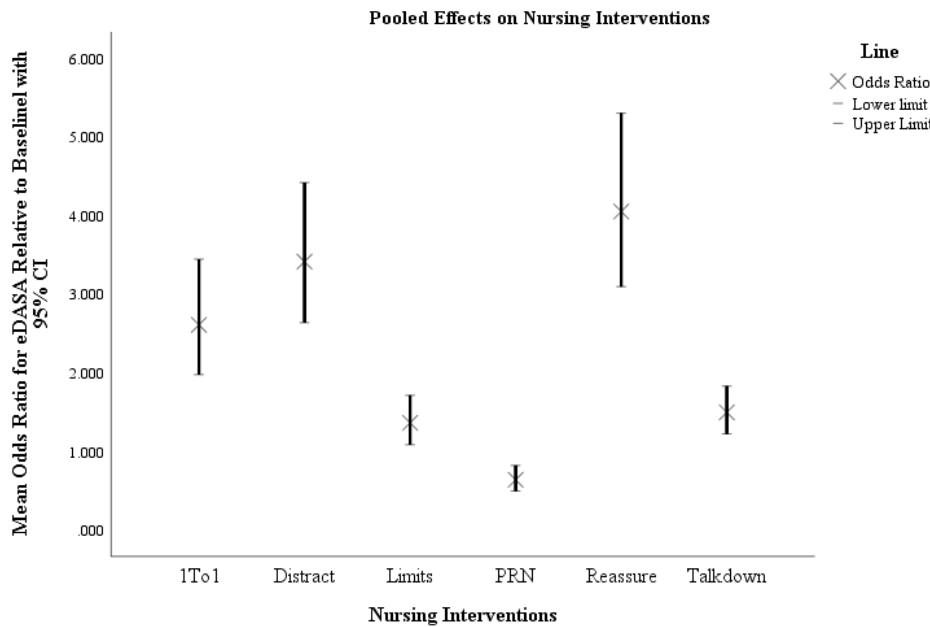


Figure 5. Effect on use of nursing interventions (Adjusted Odds Ratios). Note. 1To1 = One to one nursing, Distract = Distraction Techniques, Limits = limit setting, PRN = medication to manage behavior, Reassure = Reassurance provided, Talkdown = verbal de-escalation techniques used. OR = Odds Ratio, CI = Confidence interval.



Appendix 3: Innovation in Practice and Process and Applicability to Other Settings

Figure 1. Form used to score and record daily DASA scores, aggression and proposed staff interventions.

DASA Rating		
Domain	Score	Legend
1. Irritability	0	0. The patient has been calm, tolerant and relaxed. S/he is comfortable and relaxed in the company of other patients and with staff. 1. The patient is easily annoyed or angered and unable to tolerate the presence of others.
2. Impulsivity	0	0. The patient in the last 24 hours has been compliant with any requests and directions. 1. The patient has been impulsive and unpredictable in his/her affect or behaviour, or was quick to (over-) react to real and imagined slights, insults, and disappointments.
3. Unwillingness to follow directions	0	0. The patient has been affectively and/or behaviourally stable and composed. 1. The patient has become angry and/or aggressive s/he was asked to adhere to some aspect of her/his treatment or to the ward's routine in the last 24 hours.
4. Sensitive to perceived provocation	0	0. In the last 24 hours the patient has not become extraordinarily angry or seen everything that occurs around her/him as provocative. S/he is not 'overly sensitive' or 'provocative'. 1. The patient has tended to see others' actions as deliberate and harmful. S/he may misinterpret other people's behaviour or respond with anger in a disproportionate manner to the extent of provocation. S/he has been prickly, overly sensitive and quick to anger.
5. Easily angered when requests are denied	0	0. The patient has been calm and accepting when s/he is asked to wait whilst her/his request is attended to. S/he has been understanding and accepting that her/his request has been unable to be fulfilled at that time. 1. The patient has tended to become angry when her/his requests have not been granted immediately. S/he has been unwilling or incapable of accepting delay in gratification of her/his requests. may become surly, angry or aggressive.
6. Negative Attitudes	0	0. No negative attitudes. 1. Definite/serious negative or anti-social attitudes supportive of aggressive behaviour exhibited in the last 24 hours. This item does not refer to pessimism.
7. Verbal threats	0	0. The patient has not been verbally aggressive. 1. Definite/serious negative or anti-social attitudes supportive of aggressive behaviour exhibited in the last 24 hours. This item does not refer to pessimism.
DASA Risk Band	Low	

Record of Aggression	
During the previous 24 hours has the patient behaved aggressively in any of the following ways?	
Physical Aggression against OBJECTS Slams door, throws objects down, kicks furniture, breaks objects, smashes windows, sets fires, or throws objects dangerously.	<input type="checkbox"/>
Verbal Aggression against PATIENTS Shouts angrily, insults, curses viciously, uses foul language in anger, or makes clear threats of violence towards others.	<input type="checkbox"/>
Verbal Aggression against STAFF Shouts angrily, insults, curses viciously, uses foul language in anger, or makes clear threats of violence towards others.	<input type="checkbox"/>
Physical Aggression against PATIENTS Makes threatening gesture, swings at people, grabs at clothes, strikes, kicks, pushes, pulls hair, or attacks others.	<input type="checkbox"/>
Physical Aggression against STAFF Makes threatening gesture, swings at people, grabs at clothes, strikes, kicks, pushes, pulls hair, or attacks others.	<input type="checkbox"/>

Suggested Interventions	
Based on the DASA results, select which interventions you intend to use	
Please select the interventions you intend to use	
<input type="checkbox"/> One-to-One Nursing	
<input type="checkbox"/> Reassurance	
<input type="checkbox"/> Distraction Techniques	
Document any other actions you intend to take	

Figure 2. Aggression Prevention Protocol (APP). Practice and responding is additionally informed by provision of a published DASA+APP Nursing Practice Manual. A training video to educate staff on how to rate and formulate a preventative response on the basis of DASA scores has also been filmed to further strengthen staff expertise & practice.

THE DYNAMIC APPRAISAL OF SITUATIONAL

AGGRESSION

AGGRESSION PREVENTION PROTOCOL

NURSING PRACTICE MANUAL



DASA
Aggression prevention protocol process

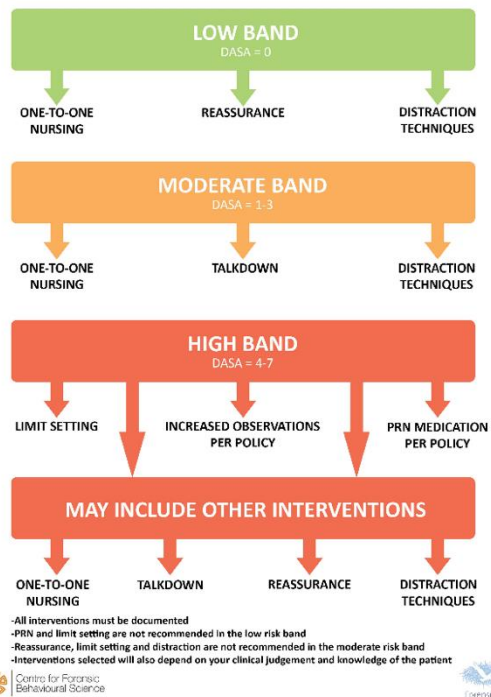


Figure 3. Forensicare is currently pursuing the creation of a data visualisation portal that will enable daily, weekly and monthly monitoring of DASA alongside aggression incidents to strengthen review of change in behavioural risk and acuity and better inform unit-level allocation of resourcing and prevention intervention.

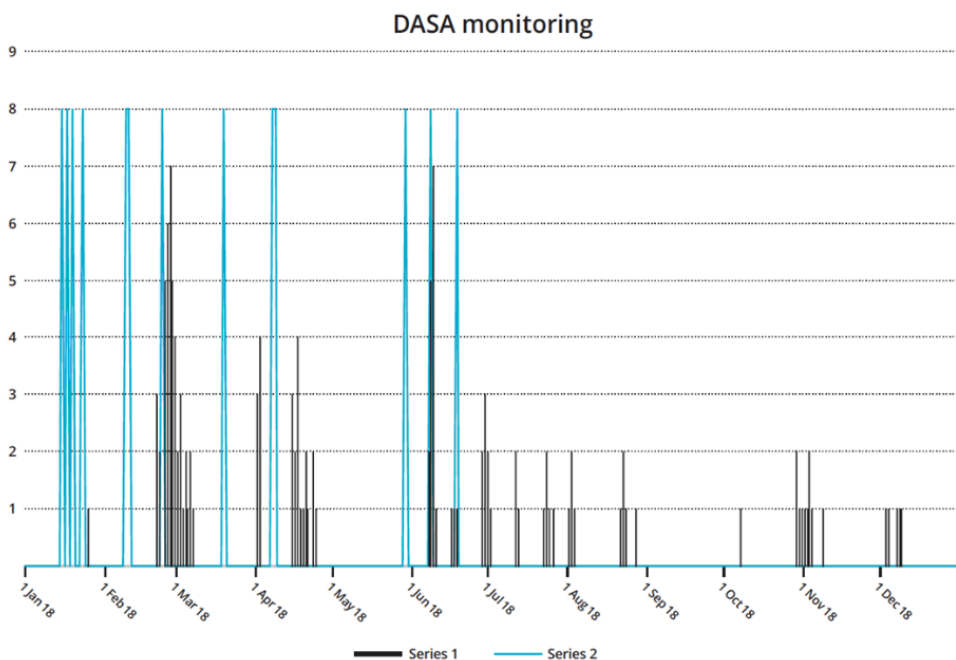


Figure 4. Illustrating uptake in other mental healthcare settings, an electronic application of the eDASA in a clinical decision support tool utilised by a health service in the United Kingdom.

DASA: IV

Dynamic Appraisal of Situational Aggression (DASA)

Nottinghamshire Healthcare
NHS Trust

DATE	PATIENTS NAME	SIGNED
13/10/2006		OWNER

Risk for imminent aggression and self-harm:

The following ratings are based on your knowledge and observations of the patient during the PREVIOUS 24 HOURS. Well-known patients are scored a Y for an increase in the behaviour described, the patient's usual behaviour while being non-violent is scored as N. (i.e., If the patient is, for example, always unwilling to follow directions but is never violent then they should be rated as N because for this patient being unwilling to follow directions is not associated with violence. However, if the patient is generally unwilling to follow directions but becomes extraordinarily unwilling to follow directions on a particular day then the rating becomes Y for this day)

RATING ITEM	RATING	
	N	Y
IRRITABILITY	<input type="radio"/>	<input type="radio"/>
IMPULSIVITY	<input type="radio"/>	<input type="radio"/>
UNWILLINGNESS TO FOLLOW DIRECTIONS	<input type="radio"/>	<input type="radio"/>
SENSITIVITY TO PERCEIVED PROVOCATION	<input type="radio"/>	<input type="radio"/>
EASILY ANGERED WHEN REQUESTS ARE DENIED	<input type="radio"/>	<input type="radio"/>
NEGATIVE ATTITUDES	<input type="radio"/>	<input type="radio"/>
VERBAL THREATS	<input type="radio"/>	<input type="radio"/>

Double Click on Item for Definition



CLINICAL EXCELLENCE AND PATIENT SAFETY

HIGHLY COMMENDED

North Metropolitan Health Service, WA

Mental Health, Public Health and Dental Services

North Metropolitan Health Service Smoke Free Mental Health Project

Heather Monteiro, Krista Coward, Joanna Fagan, Viki Pascu and Michael Sitas

AIM

The Smoke Free Mental Health Project (the Project) aimed to reduce smoking on mental health service sites to protect patients, staff and visitors from exposure to environmental tobacco smoke (ETS). A key objective was to improve clinical staff knowledge, skills and confidence to manage nicotine dependence among patients using evidenced-based behavioural support interventions and pharmacological therapies such as Nicotine Replacement Therapy (NRT).

SUMMARY ABSTRACT

The Smoke Free Mental Health Project (the Project) was conducted in North Metropolitan Health Service (NMHS) Mental Health, Public Health and Dental Services (MHPHDS), at multiple sites including Graylands Hospital.

Cigarette smoking is the leading preventable cause of death in Australia. People with mental illness have rates of smoking 2-3 times higher than that of the general population and are more likely to experience ill health and death as a result of smoking related illnesses (NMHS MHPHDS Mental Health, 2019). Cigarette smoking and nicotine withdrawal can also impact on symptoms of mental illness and effectiveness of mental health and medical treatment. Despite this, an Australian study of public psychiatric inpatient units found that over one-third of inpatients started smoking during their admission, with cigarettes often provided to patients by staff (BPACNZ., 2014). There is also evidence that both patients and nursing staff have begun smoking as a result of exposure to the smoking culture in mental health settings (Lawn and Campion, 2013).

Smoking on health sites exposes patients and staff to environmental toxins, is a proven health risk and an occupational health and safety issue for staff, patients and the community. The Smoke Free WA Health System Policy, a mandatory policy creating smoke-free health services, includes a partial exemption for involuntary inpatients at Mental Health Units (MHUs) in WA, enabling involuntary inpatients to smoke tobacco during their admission. Due to the difficulties in

operationalising the exemption, invariably voluntary patients have also smoked on site.

While people with mental illness who smoke have higher levels of nicotine dependence, they are just as likely to want to address their smoking behaviours and just as likely to alter their tobacco use with appropriate support as the general population. However, people with mental illness are less likely to be offered assistance with their nicotine dependence.

Behavioural and pharmacological interventions are effective in helping patients abstain from smoking, making them a vital component of smoke-free health services. They can also help to maintain improvements in smoking behaviour in the long term after discharge from MHUs. Not engaging in smoking cessation interventions acts as a lost opportunity for significantly improving mental and physical health outcomes of patients.

To reduce the impact of smoking and mental health the NMHS MHPHDS Executive committed to creating a totally smoke-free health service, thereby removing the exemption for involuntary mental health inpatients as of 27 August 2019. Governance systems were established, led by a Steering Group chaired by the Director Public Health. The Project aimed to support Mental Health staff and patients through this transition, adopting a supportive approach by improving clinical staff knowledge, skills and confidence to manage nicotine dependence among patients using evidenced-based behavioural support interventions and pharmacological therapies such as Nicotine Replacement Therapy (NRT).

Key activities included:

1. The development of new Smoking Care Guidelines and tools to guide staff to systematically identify patients who smoke and provide support to address nicotine dependence using the **ABCD** (Alfred Health, 2015) approach: **Asking**; providing advice (**Brief** intervention); recording the action taken at the point of hospital discharge (**Communication at Discharge**).
 - A new NRT Assessment tool was developed to support staff to ask patients about their smoking status and assess nicotine dependence and management on admission.
 - The Guidelines support staff to provide advice about pharmacological therapies such as NRT to replace the nicotine from smoking and reduce the symptoms of nicotine withdrawal. Evidence suggests that NRT increases the success of quitting smoking by 50-70%.

- The Guidelines also endorse the safe use of higher dose NRT patches in combination with a faster acting NRT to better manage nicotine withdrawals. Combining the nicotine patch with an oral form of NRT can increase quit rates by 34–54% compared to using the patch alone. Due to its proven efficacy, the nicotine mouth spray has also been added to the NRT options available to patients.
 - Behavioural support interventions, or non-pharmacological interventions, can take the form of advice, encouragement, discussion or distraction activities. The Guidelines now provide evidence based non-pharmacological interventions that can be offered on the ward. Carbon monoxide monitors have also been introduced to measure expired carbon monoxide levels which has shown to be useful to demonstrate the reduction in smoking to and verify progress.
2. Face-to-face Smoking Cessation Support training was developed and delivered to more the 460 clinical staff to support the implementation of the new Guidelines, which proved to be effective and helped to ensure a consistent approach in supporting patients who smoke across the health service. This training has now been adapted into an e-Learning program and embedded into the staff induction program.
 3. To avoid the risk of patients experiencing symptoms of nicotine withdrawal if unable to access NRT in a timely manner, a Nurse Initiated Nicotine Replacement Therapy Policy was introduced to enable the nurse in charge of the shift or the delegated registered nurse to initiate NRT. This had previously required a medical staff member to initiate NRT.
 4. Throughout the course of the implementation of the Project, nine guest speakers presented best practice evidence on smoking and mental health to staff. This included seminars with representatives from Quit Victoria and Alfred Health (Victoria), supported by Cancer Council WA (CCWA).
 5. The Smoke Free NMHS Intranet Hub developed as part of this Project proved to be an effective way to increase staff awareness about the Guidelines as well as information about smoking cessation training, resources and evidence.
 - All NMHS staff are now informed of the Smoke Free WA Health System Policy at induction and are referred to the intranet hub for more information.

Key outcomes include:

1. The development of MHPHDS Smoking Care Guidelines for clinical staff, in combination with a

tailored face-to-face Smoking Cessation Support training package. Almost 70% of relevant staff at Graylands Hospital completed this training (n=282). Staff completing post-training reported increases in confidence to manage smoking onsite (56%); knowledge to manage nicotine addiction among patients (73%); and likelihood to encourage patients cut down or quit smoking (76%).

2. Pharmacy records show increased uptake of NRT. At Graylands Hospital, the number of patients accessing NRT increased by 76%. Incidentally, some patients have now reconsidered their smoking behaviours and have subsequently reduced or quit smoking.
3. An extension of a program of distraction activities was established for patients and increased from five to seven days, which resulted in a five-fold increase in Smoking Support Behavioural Interventions in wards with long-stay patients.
4. Despite the perceived increased risk of patient aggression resulting from nicotine withdrawal pre-intervention, hospital security data suggests a reduction in incidents of physical violence and aggression where smoking may have been a contributing factor.
5. Onsite evidence of smoking decreased at Graylands Hospital by 60%; and at Selby Lodge by 82%. Tobacco-related products such as lighters, and waste have been removed from patient areas; the sale of cigarettes at the volunteer-run Graylands Canteen has ceased; and new positive smoke-free signs installed creating a safer environment for mental health patients, staff and visitors.

Conclusion

The Smoke Free Mental Health Project (the Project) aimed to support Mental Health staff and patients through its transition to become totally smoke-free. As a result, new policies and practices ensure nicotine dependent mental health inpatients are given the support they need to reduce and cease smoking whilst in the care of NMHS.

NMHS is now a role model for other mental health services in WA, and advocates for the introduction of evidenced-based, multi-strategic approaches to care for mental health patients who smoke.



Sydney Local Health District, NSW**RPA Virtual Hospital****rpavirtual – a new way of caring**

*Freya Raffan, Miranda Shaw, Dianna Jagers,
Owen Hutchings and Cassandra Dearing*

AIM

The aim was to introduce a new virtual hospital model and to implement a clinical safe virtual model of care for COVID-19 patients in home isolation or health hotel quarantine.

SUMMARY ABSTRACT

An analysis of population projections and service demand was a key driver in considering new, integrated and sustainable models of outpatient and community care in Sydney Local Health District (SLHD). By 2036, the SLHD population of 700,000 is projected to increase by 43%. Combined with increasing rates of chronic disease and a rapidly ageing population, an 84% increase in emergency department presentations is also predicted by 2026.

Virtual models of care have been can reduce demand on 'bricks and mortar' hospital inpatient care and outpatient clinics and increase patient and carer satisfaction by supporting patients to remain in their own home rather than in hospital.

Whilst there were examples of long established virtual care services in NSW, these were largely hospital in-reach models rather than direct virtual care delivery to patients. Consultation to inform the introduction of a virtual hospital in SLHD was extensive and focussed on designing the physical infrastructure, digital solutions and initial clinical models of care.

The RPA Virtual Hospital, known as rpavirtual, was launched in February 2020 as an alternative, sustainable solution to increasing demand for healthcare in Sydney.

rpavirtual is a new model of care which combines SLHD's integrated hospital and community care with the latest digital solutions. rpavirtual acts as a bridge between hospital specialist services and patient care in the community. A purpose built 24/7 Virtual Care Centre was established on the Royal Prince Alfred Hospital campus and equipped with 'Care Pods' that include videoconferencing technology and the ability to remotely monitor patients with wearables. See Appendix 1 for photos of rpavirtual.

A variety of patient cohorts have been enrolled for care including palliative, community mental health, cystic fibrosis and other chronic conditions. On March 5 2020, rpavirtual began a rapid redesign to prepare to deliver virtual health care to stable patients with COVID-19 in the community using remote monitoring. On 11 March, rpavirtual commenced remote monitoring of COVID-19 positive patients and later commenced care to COVID-19 negative patients in health hotel quarantine.

Over 3,500 unique patients have been cared for in the first seven months of operation, with high reported patient satisfaction. Evaluation results to date confirm that hospital type care can be delivered safely in the community with the right technology and governance. To date, 365 patients have provided feedback on their experience of care with 86.8% rating their care as good or very good and 91.4% feeling confident knowing their condition is monitored virtually. See Appendix 2 and 3 for patient experience data.

Within a short period, rpavirtual has positioned itself as a leader in the Australian virtual healthcare space, informing state-wide strategy for virtual care and has been critical to the New South Wales' response to the COVID-19 pandemic.



WA Country Health Service, WA

Geraldton Hospital

SAFER TOOL PROJECT – Partnering with consumers to improve outcomes and minimise risk of falling and pressure injuries*Narelle Dennett, Karen Zayco, Liza Doble, Kirra Pallant and Shannon Mcaullay***AIM**

The SAFER Tool was designed to provide a practical pictorial educational tool to consumers and staff on the Falls Risk and Management Plan (FRAMP) Minimum Interventions. The SAFER Tool was designed in collaboration with consumers and staff to facilitate key education messages on falls prevention, pressure management and cognitive impairment to minimize risk during hospital admission.

SUMMARY ABSTRACT

The NSQHS Standard 5 - Comprehensive Care, aims to ensure that risks of harm for patients during

health care are prevented and managed through targeted strategies. It includes actions related to falls, pressure injuries, nutrition, mental health, cognitive impairment and end-of-life care. WA Country Health Service (WACHS) acknowledges that completion of a falls risk assessment is the first step in preventing falls. The MR521 Falls Risk Assessment and Management Plan (FRAMP) contains minimum interventions to be implemented for all general adult inpatients. As part of falls prevention and education it is required that these minimum interventions are put in place by staff and communicated to patients. The SAFER Tool Project focused on presenting these minimum interventions in a pictorial tool. SAFER is an acronym derived from the actions "Show, Aids, Facilitate, Educate and Remove". The SAFER tool comprises an A3 poster positioned bedside of all general ward beds. It is utilised as an education tool for patients, carers, nursing, medical, allied health and support services staff to raise awareness to falls risk, cognitive impairment, management and prevention strategies.



CLINICAL EXCELLENCE AND PATIENT SAFETY

TABLE OF SUBMISSIONS

<p>Alfred Health Clinical Governance Unit Behind closed doors: Improving the safety and quality of patient care through the novel application of Telehealth within the acute inpatient setting <i>Lucy Martiniello, Billy Wickham, Mehmet Gurkan, Duane Miller, Courtney Royston, Gordon Bingham, Erica Tong, Nicole Rasmussen</i></p>
<p>Royal Perth Bentley Group Patient Support Services/SAFE Department (SAFE/BeSAFE Teams) Improving Patient Safety Through utilising an Electronic Task Tracking Tool <i>Katherine Birkett, Diana Teow, Bill Poposki, Sean Sng, Tim Bowles</i></p>
<p>Bolton Clarke (RDNS Ltd) Care Innovation Team Achieving clinical excellence for older Australians: the Bolton Clarke Service Delivery Framework and Models of Care for Community and Residential Aged Care settings <i>Janeen Cato, Kath Paine, Tracy Ayles, Leanne Davey, Kylie Elder, Kate McLeod, Fleur O'Keefe</i></p>
<p>Centenary Hospital for Women and Children Reducing early births at the Centenary Hospital for Women and Children Fetal Medicine Unit <i>Roberto Orefice, Boon Lim, Julia Smythe</i></p>
<p>Canossa Hospital (Caritas) Outpatient Department Enhancing patient care in the Out-patient Department of Canossa Hospital by an interactive “nursing function module” in the Hospital Information System <i>David Tai Wai Ho, Lucy Chik Pui Choy, Bryan Man Hay Chan, I Lee, Alan Young, Amy Chan Chui Yuk, Lung Suet Fan, Nursing Manager</i></p>
<p>Royal Adelaide Hospital Neurosurgery Department Reducing Hospital Length of Stay for Brain Biopsy Patients from 3.9 days to 23 hours with the stretch goal of performing brain biopsy as a day procedure <i>Jai Kaur, Adam Wells</i></p>
<p>St John of God Midland Public and Private Hospitals Emergency Department ECG audit <i>Carolyn Chapman, George Petrov, Helen Daniels, Bhaumik Mevavala</i></p>
<p>Sydney Local Health District (SLHD) – Concord Hospital Psychology – Mental Health The effectiveness of crisis interventions, targeted psychological strategies and support during isolation and/or quarantine. <i>Lila Petar Vrklevski, Owen Hutchings, Cassandra Dearing, Miranda Shaw, Victor Storm, Sarah Whitney</i></p>
<p>Sydney LHD Concord Repatriation General Hospital Department of Intensive Care Services The role of simulation in preparing the healthcare workforce for providing CPR during medical emergencies in the COVID-19 pandemic <i>Christopher Yu, Wesley Yao Lin Yang, Gabriella Charlton, Christine Ma, Seshika Dinali Ratwatte, Clarence Yeong, Asim Shah</i></p>
<p>Eastern Health Quality, Planning and Innovation Imbedding Open Disclosure as part of normal obstetric care – a multi modal approach <i>Julie Preston</i></p>
<p>Fairfield Hospital Paediatrics and Operating Theatres Improving Surgical Management for Paediatric Patients</p>



<p><i>Wayne Phillips, Liecer Daley</i></p> <p>Gold Coast Health GCHHS Intensive Care Services Channel 101: Reducing the impact of DELIRIUM in Intensive Care <i>Kate Elliott, Jack Matulich</i></p>
<p>Gold Coast Hospital and Health Service After Hours Care Unit, Centre for Health Innovation In Hours Care to All Hours Care' Gold Coast Hospital and Health Services transformation of After-Hours Care <i>Hayley Frieslich, Crystle Dries, Melany Harper, Tracey Doherty, Rachael Smithson, Elisha Roche</i></p>
<p>John Hunter Hospital HNELHD Maternity & Gynaecology services Maternity Assessment Bay: Keeping Women Safe <i>Wendy Tsang, Angela Boulton, Andrew Woods, Cathy Richards, Jacqueline Allabyrne, Mandy Hunter</i></p>
<p>Hornsby Ku-Ring-Gai Hospital Aged Care and Rehabilitation Services NSLHD Frailty Initiative <i>Susan Kurrle, Linda Xu, Catherine Richards, Katie Lee, Lisa Eldridge, Jordana Pancetta, Lara Pasternak, Annie Yu</i></p>
<p>Hornsby Ku-ring-gai Hospital Orthopaedic Fracture Clinic No Bones About it <i>Katie Lee, Bronwyn Nolan, Deb Stewart, Matthew Smith, Sam Ah Kit, Jane Waldron, Clare Skinner, Anna Abeska</i></p>
<p>Icon Cancer Centre Australia Quality Redesign and implementation of new patient health history and patient assessment medical records in an integrated cancer care setting <i>Kyla Snelling, Joanne O'Shea, Renee McMullen, Justine Morrow, Amanda Waldon, Clare Smith</i></p>
<p>Icon Cancer Centre Quality Team and Icon Nurse Education Team (INET) Development and implementation of a revised troubleshooting guide for the access and management of Central Venous Access Devices (CVADs) in day oncology <i>Cheree Morgan, Justine Morrow, Joanne O'Shea, Kyla Snelling, Katrina Sankey, Anne Fitzgerald, Amanda Connolly, Renee McMullen</i></p>
<p>International Medical Centre Surgery/Infection Control/ Quality Improvement and Patient Safety Reduce postoperative CAUTI occurrences for surgical cases <i>Dalia Alsaadi, Taher Yunus, Nashaat Hamza, Reem Alshaikh, Edelmira Q. Cabagan, Najla'a I. Baraja, Yasser Ramadan and Feras Haddad</i></p>
<p>Illawarra Shoalhaven Local Health District (ISLHD) Emergency Services "I can breathe" Implementation of a chest injury care bundle to prevent adverse events. <i>Kate Curtis, Michael Watts, Sharyn Balzer, Soni Putnis, Martin Jones, Nick Maytom, Anne Smith, Sarah Kourouche</i></p>
<p>Illawarra Shoalhaven Local Health District Emergency Department Shoalhaven District Memorial Hospital Time is Brain <i>Donna Jay, Rik Wheatley, Lhyriel Smith, Emma Griffiths, Bradley Scotcher</i></p>
<p>Illawarra Shoalhaven Local Health District Midwifery Unit, Wollongong Hospital Tears Will Fall <i>Fiona Reid, Helen Donovan, Cindy-Anne Johnston</i></p>
<p>Karitane Karitane Integrated Care Oran Park – An Exemplar Integrated Care Hub for the First 2000 Days <i>Grainne O'Loughlin, Justin Duggan, Melanie Hughes, Steven Weultjes, Martha Vasquez, Angela Wood, Penny Jones</i></p>
<p>Hong Kong Baptist Hospital Nursing Administration Office Multidisciplinary Fall Prevention Strategies to Reduce Falls in hospital</p>



<p><i>Li Yuen Man Hilda, To Ka Wing, Cheung Ching Yee Cindy, Cheung Kim Keung Dennis, Yuen Wing Sze Jammie, Wong Oi Lan Ellen, Lee Wai Yee Susanna</i></p>
<p>North Metropolitan Health Service Mental Health Public Health & Dental Services Special Needs Dental Clinic “Maggie Goes To The Dentist” <i>Tamarai Selvam, Christina Lin, Martin Glick, Magda Guzman, Rae Ann Mumford, Sarah Cooper</i></p>
<p>St John of God Midland Public and Private Hospitals Quality and Risk Hook, Line and Sinker – a fishbone in action <i>Tracey Piani, Jo Jones</i></p>
<p>Metro North HHS Metro North Mental Health The journey of developing a Mental Health Consumer and Carer Partnership Co-Designed Framework <i>Shelley Kulperger, Lisa Jones, Shirley Anastasi</i></p>
<p>Metro North Hospital and Health Service Metro North Mental Health/ Adis 24/7 Alcohol and Drug Support Adis-Link: Assertive referral model for streamlined alcohol and other drug treatment <i>Hollie Wilson, Kim Sander, Jenny Mitchell, Anthony Bligh</i></p>
<p>National Critical Care and Trauma Response Centre Department of Health NCCTRC AUSMAT – HOPES - Helping Others Prepare for Emergency Situations SODE – Supporting Others During Emergencies TOTES – Teaching Others Through Emergency Situations <i>Jan Gibbett, Jason Gates</i></p>
<p>North Metropolitan Health Service MHPHDS Mental Health Joondalup Community Mental Health Clinic The Clozapine Journey <i>Carey Taylor, Alex Dare, Fiona Laird, Mechaiel Farag</i></p>
<p>North Metropolitan Health Service Mental Health, Public Health and Dental Services – Public Health North Metropolitan Health Service Smoke Free Mental Health Project <i>Heather Monteiro, Krista Coward, Joanna Fagan, Viki Pascu, Michael Sitas</i></p>
<p>Northern Health Risk Management Addressing Hospital Acquired Complications by harnessing local clinicians and multidisciplinary expert groups with data and analysis that is standardised from ward to board <i>Matthew Soo, Bill Shearer, Christine Polmear</i></p>
<p>Northern Health Emergency Department / Project Management Office & HRO Transformation Improving quality and safety of patient care through in-situ simulation <i>Nancy Sadka, Tracey Martin</i></p>
<p>Melbourne Health NorthWestern Mental Health – Mid West Area Mental Health Service – Community Team Outer The Health Improvement Clinic (HIC), a multidisciplinary physical health service incorporating the Mid West Area Mental Health Service – Outer Community Team and Djerriwarrh Health Service <i>Alexis May</i></p>
<p>Odyssey House NSW Corporate Executive A big response to a bigger threat by the little cousins of healthcare: Alcohol and Other Drug Services fast-tracking innovation of services to continue supporting vulnerable people <i>Chloe Tadorian, Julie Babineau, Karen Becker</i></p>
<p>Royal Brisbane and Women’s Hospital Metro North Hospital and Health Service Whole-of-hospital transformation: Implementing Q-ADDS in the RBWH <i>Julian de Looze, Kristina O’Dwyer, Juliette Mewton, Shaune Gifford, Shane Townsend, Claire Muller, Meaghan Osbourne, Mia McLanders</i></p>



<p>Peninsula Health Emergency, Anaesthetics, Paediatrics, Dietetics, Food Services, Support Services, Safer Care Unit Improving anaphylaxis recognition and treatment <i>Shyaman Menon, Rob Jewson, Helen Kolawole, Alex Mclean, Gav Chaves, Karen Edis, Sue Sinn</i></p>
<p>Metro North Hospital and Health Service Clinical Governance, Safety, Quality & Risk Office, Metro North HHS A multi-intervention approach to minimising preventable iron staining <i>Martin Canning, Ian Coombes, James Collins, Katherine Losinski, Ann Whitaker, Nicola Harper, Mark Butterworth, Noelle Cridland</i></p>
<p>Princess Alexandra Hospital Emergency Department Response to Occupational Violence Emergencies (ROVE): The clinical, collaborative approach to Occupational Violence management in the healthcare setting <i>Karen Taurima, Sue Galbraith, Carl Shannon, Scott Nichol, Ben Horan, Ben Learmont, Duncan Brown, Krimesh Shukla</i></p>
<p>Redcliffe Hospital, Queensland Health Pharmacy Department Theatre MedicineWISE Project: The Introduction of the Perioperative Pharmacist <i>Nicholai De La Cruz, Geoffrey Grima</i></p>
<p>Northern Sydney Local Health District Neonatal Intensive Care Unit, Royal North Shore Hospital (RNSH) Keeping Sweethearts Together <i>Karen Lawrence, Carla Saunders, Mary Paradisis, Alexis Fox, Eveline Staub, Nicholas Williams</i></p>
<p>Northern Sydney Local Health District NSLHD Carer Support Service NSLHD Carers @ the Bedside program <i>Philippa Bernauer, Barbara Lewis</i></p>
<p>Royal Brisbane and Women's Hospital (RBWH) Emergency and Trauma Centre, Critical Care and Clinical Support Services Clinical Audit of Shoulder Dislocations presenting to RBWH Emergency and Trauma Centre <i>Jordan Young, Gary Mitchell, Janelle Heine</i></p>
<p>Royal Brisbane and Women's Hospital Medical Services and Department of Internal Medicine and Aged Care UP LATE – Improving After Hours Care <i>Julian de Looze</i></p>
<p>Royal Brisbane and Women's Hospital RBWH Accelerated Discharge & Rapid Re-entry – Plastic Surgery Pathway <i>Sandra Gosley, Carmen Mauchline, Kate Dickson, Tia Kemp, Joanne James, Vidhi Sharma, Lynda Potter, Matthew Peters</i></p>
<p>Royal Brisbane and Women's Hospital Department of Anaesthesia & Perioperative Services Minimising hypothermia after surgery <i>Geoffrey Messer, Gunjan Chawla, Charles Cheung, Nathan Peters, Kerstin Wyssusek</i></p>
<p>Royal Perth Hospital, East Metropolitan Health Service Pharmacy Department CHOPA – Clinical HandOver for Pharmacists Application. Improving clinical handover, communication and documentation among pharmacists <i>Scott Ripley</i></p>
<p>East Metropolitan Health Service Royal Perth Bentley Group East Metropolitan Health Service NDIS Access Project: A pilot project to enhance successful access to the National Disability Insurance Scheme for Western Australians with psycho-social disability <i>Helen Ayres, John Buchanan, Alex Cann, Andrew Buzzacott</i></p>
<p>Royal Perth Bentley Group (RPBG) Your Time Counts Program RPBG Daily Stand Up Initiative <i>Donna Coutts-Smith, Anhnue Nguyen</i></p>
<p>Royal Perth Bentley Group</p>



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<p>SA Health Adelaide Dental Hospital SA Dental Service, Central Adelaide Local Health Network Digital and telehealth triage and consultation for emergency oral and maxillofacial surgery cases under COVID-19 service restrictions <i>Michael Bradley</i></p>
<p>SA Health Health Promotion Unit, SA Dental Service Central Adelaide Local Health Network Creating an Autism Friendly Dental Setting <i>Jane Heron-Kirkmoe, Sue Stevens</i></p>
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<p>Central Adelaide Local Health Network, State-wide Clinical Support Services, SA Pathology SA Health COVID 19 Drive Through Swab Collection Services <i>Genevieve Sturman, Sarah Taylor</i></p>
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<p>St John of God, Hawkesbury District Health Service Perioperative Services The Quiet Project <i>Sharon Fitzgerald, Candice Mussing</i></p>
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<p>Sydney Dental Hospital and Oral Health Services, NSW Health Department of Paediatric Dentistry Smile Stronger, Smile Longer</p>



<p><u>Yvonne Chau</u></p> <p>St Vincent's Health Network St Vincent's Hospital Digitalising a rural haematology service in the country town of Griffith, NSW <u>Nada Hamad, Eleni Mayson</u></p>
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<p>West Moreton Health Knowledge Framework Clinical Advisory Group West Moreton Region Care at the End of Life Knowledge Framework <u>Roslyn Holloway, Carol Hope, Helen Gregory, Emma Hart, Sharyn Stieler, Lanette Lewis, Sarah-Jane Gough, Elizabeth Davis</u></p>



<p>West Moreton Health Ipswich Heart Failure Service – Chronic Conditions Service West Moreton Health virtual care model for medication titration of heart failure patients in the community setting <i>Alicia McClurg, Rebecca Tomlinson, Ben Shea</i></p>
<p>West Moreton Hospital Health Service Chronic Conditions Service Reducing wait lists and optimising clinic appointment slots: Dietetics service delivery model improvements <i>Michelle Lang, Rebecca Thompson, Penelope Rayner, Shelley Smith, Melanie McAndrew</i></p>
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<p>WSLHD Mental Health Services Blacktown Clozapine clinic Clozapine Consumer Safety during COVID-19 Pandemic <i>Harpreet Kaur, Sangeetha Pillai, Selena Leung, Ramanathan Ganapathy, Anoop Sankaranarayanan</i></p>
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NON-CLINICAL SERVICE DELIVERY

WINNER

Redcliffe Hospital, QLD

Pharmacy Department

Drive Through Pharmacy Collections – Minimising hospital visits for vulnerable patients

Michael Sparqo, Ann Whitaker, Geoffrey Grima and Alysha Hoogendoorn

AIM

In response to COVID-19 and physical distancing requirements, a drive-through collection service for medications was created. This reduced the number of patients in the hospital building waiting and collecting from the front counter of pharmacy. Further, this initiative aimed to reduce the higher risk of infection for special patient groups that were immune-compromised or medically vulnerable.

SUMMARY ABSTRACT

Description

Outpatient prescriptions and colonoscopy bowel preparation medications were supplied to patients as they waited in their vehicles. Patients drove to the designated parking area and called a dedicated telephone number to advise pharmacy of their arrival. The service was utilised by patients and their carers as well as other hospital and community-based staff collecting medications for patients. It minimised staff waiting times and foot traffic in the hospital. Medicine counselling that was normally performed face-to-face at the pharmacy counter was instead conducted via telehealth or telephone.

Action

The transition required changes to established processes to ensure service levels were maintained. Medicine counselling was conducted via telehealth or telephone. A dedicated phone number was set up for patients to call on arrival. Approval was granted to have patients park in a dedicated area at the hospital entry. A new position was established for an Advanced Scope Pharmacy Assistant to prepare and organise of drive-through bookings, and delivery of medications to vehicles. Patients with repeat prescriptions were actively encouraged to leave them on file in the department, and to call when a refill was required.

Evaluation

An online consumer satisfaction survey was used to evaluate the service. 90% of respondents were 'extremely satisfied' and 10% were 'very satisfied' with the overall experience. Other questions assessed whether patients felt they had received sufficient information about their medicines, waiting times with the service, and their wish for the service to continue. Responses to these questions were similarly positive. A review of patient waiting times also demonstrated a significantly decreased waiting time in the hospital, while avoiding the need for car parking. This eliminated issues with patient car parking as well as making more parking spaces available for others. 669 patients received deliveries between March and June, helping to reduce foot traffic into the hospital. Our pharmacists were able to plan their workflow to counsel patients between hospital discharges and inpatient supplies, enabling a more relaxed and comprehensive education provision.

Implications

The drive-through service demonstrated that pharmacy services can be effectively delivered using technology applications such as telehealth and the telephone. Feedback was very positive from patients. Overall convenience and the time-saving benefits were commonly reported comments. The service also demonstrated the facility's patient-focused approach. By proactively adjusting services to minimise foot traffic into the hospital environment, the potential exposure of these vulnerable patient cohorts to infectious diseases was reduced. These features have positive benefits with patient compliance improving as a result. To further streamline the service, the department is currently assessing suitability of an Advanced Scope Pharmacy Assistant providing counselling for colonoscopy bowel preparations. Results from the initial trial was used to demonstrate the ability to reinvigorate the service in August due to the re-emergence of local COVID-19 cases.



REPORT

APPLICATION OF ACHS PRINCIPLES

1. Consumer Focus

Patients presenting to hospital pharmacies for outpatient prescriptions often require specialised medicines. These medicines are often not available from community pharmacies due to their high cost and the lower frequency of use. These medicines include immunosuppressants, specialised antibiotics and antivirals for chronic infection control. They are used to treat conditions such as Cystic Fibrosis, HIV infection and for patients who need post-transplant management. This group of patients are at higher risk of infection and have a greater consequence if they have an infection. Further, these patients already spend a disproportionately large amount of time in healthcare facilities. The drive through collection service reduced the number of visits and the total amount of time that these already time-poor patients needed to be at the hospital to obtain their regular medicine supply. This improved patient safety and was appreciated by patients based on their feedback in the survey.

The hospital car park is located on the fringes of the hospital grounds, and is generally at capacity. To park and walk to the pharmacy department takes time and presents problems for some patients with mobility issues. The drive through medicine collection area was located right outside of the main entrance to the hospital. Patients also benefited by receiving medicines in the privacy of their own car, with minimal waiting time.

An online consumer engagement survey was conducted from the start of the service, which provided timely feedback. The responses were used to adapt and improve the service. The results are presented below.

2. Effective Leadership

The drive through service was implemented quickly and involved a change to processes in the pharmacy and hospital. It required all staff to actively promote, engage and train others at short notice. The facility supported the change and have recognised the positive effect it has achieved. An Advanced Scope Pharmacy Assistant was trained to coordinate the bookings and collections. This training also expanded the scope of practice for an Advanced Pharmacy Assistant, with the intent to

include explanations of the preparations used for colonoscopies.

The drive through collection service was reinvigorated at a day's notice late in August when the decision had been made to limit patient visitation to the hospital. This was in response to an increase in cases of Covid-19 in the nearby area. Through effective communication and refresher training, the number of drive through collections quickly reached the highs levels conducted previously.

3. Continuous Improvement

Once implemented, the drive through collection service was modified based on staff feedback and feedback from patients via the online survey. Some of the modifications made were to increase the flexibility of collection times with a focus on enabling collections by patients both before and after their work shifts. Patient payments were made in advance at the time of ordering, to reduce the need for patients to call back after the collection and effectively streamline an entire step of the process for patients and staff. Staff involved in counselling patients on new medicines began booking the collection on the same phone call to further improve efficiency. After undergoing training, the pharmacy assistant became able to assess patient's understanding of the pre-admission process for colonoscopies and was able to refer to the pharmacist for further education. We have begun the credentialing process for an advance scope pharmacy assistant to provide pre-procedural medication counselling to patients.

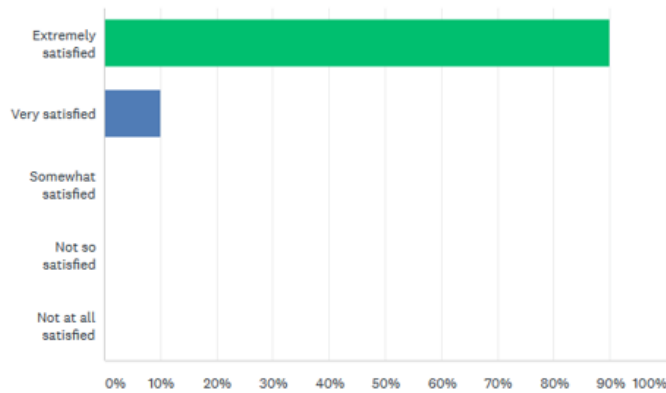
4. Evidence of Outcomes

The drive through service initially operated from late March until the end of June. Over this time a total of 669 patients received a medicine delivery, contributing to a large reduction in patient numbers in the hospital foyer and waiting areas. An online consumer satisfaction survey was conducted during the operation of the service. A range of questions were asked to assess the overall satisfaction, the perceptions of how long the process took, an assessment of whether the patient received enough information about their medicines and whether patients felt they had the opportunity to ask any questions about their medicines. The results of the responses are below:



Overall, how satisfied were you with the experience of our new drive through collection service?

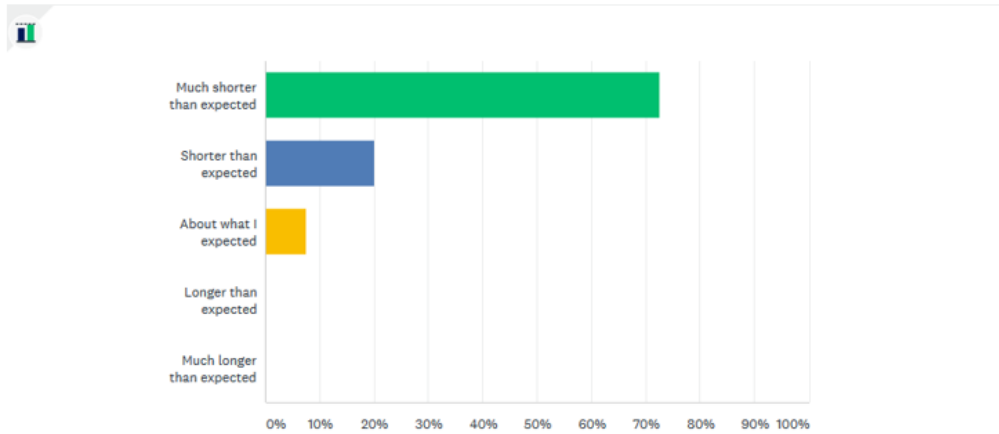
Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES
Extremely satisfied	90.00% 36
Very satisfied	10.00% 4
Somewhat satisfied	0.00% 0
Not so satisfied	0.00% 0
Not at all satisfied	0.00% 0
TOTAL	40

How much time did the drive through collection process take?

Answered: 40 Skipped: 0

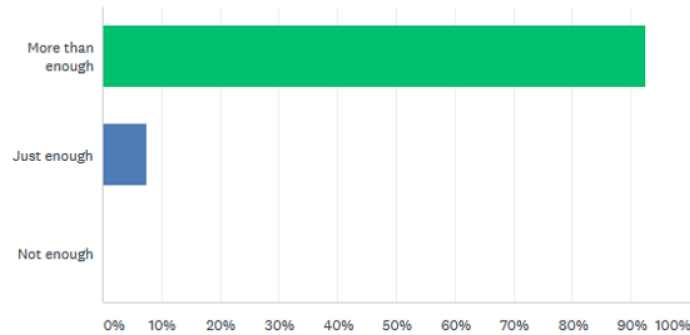


ANSWER CHOICES	RESPONSES
Much shorter than expected	72.50% 29
Shorter than expected	20.00% 8
About what I expected	7.50% 3
Longer than expected	0.00% 0
Much longer than expected	0.00% 0
TOTAL	40



Did you receive sufficient education regarding your medicines over the phone?

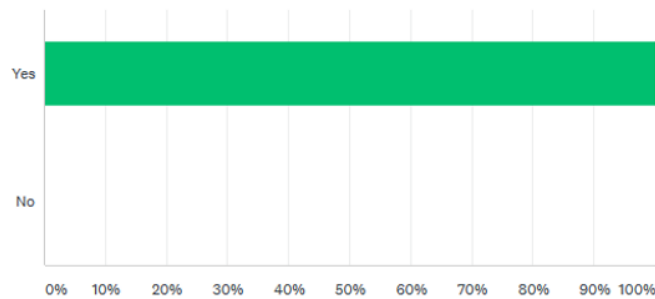
Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES
More than enough	92.50% 37
Just enough	7.50% 3
Not enough	0.00% 0
TOTAL	40

Did you feel you have sufficient opportunity to ask any questions you might have about your medications?

Answered: 40 Skipped: 0



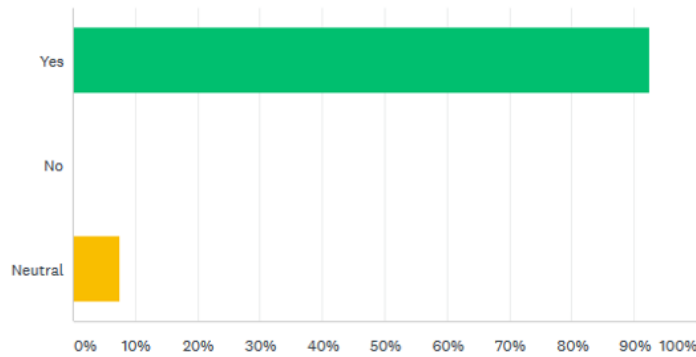
ANSWER CHOICES	RESPONSES
Yes	100.00% 40
No	0.00% 0
TOTAL	40

An overwhelming majority of patients responded that they would like to see the service continue



Would you like to see this service continue throughout and possibly beyond the current pandemic situation?

Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES
Yes	92.50% 37
No	0.00% 0
Neutral	7.50% 3
TOTAL	40

Did you find any challenges with this service?

Answered: 31 Skipped: 9

- No, staff communications are excellent. Quick and easy process to pick lifesaving drug up. Thank you for providing this service.
 5/8/2020 2:08 PM [View respondent's answers](#) [Add tags](#)

- Definitely not. On arrival at scheduled time, phone to identify, the medication arrived in less than a minute. Identity check was easy. The attendant was extremely polite and the whole process took less than three minutes
 5/6/2020 1:27 PM [View respondent's answers](#) [Add tags](#)

The final question of the survey offered patients the opportunity to provide ideas to improve the drive through service or any other feedback. Some ideas included a signed and designated pharmacy car space, being able to order their medicines online and being able to pay for their medicines via BPAY or bank transfer.



Is there anything that you think would improve the drive through collection service, or any other feedback you would like to provide?

Answered: 29 Skipped: 11

- No not at present it was very efficient and i was extremely pleased. It is a great idea and definitely should be continued permanently.
5/12/2020 1:32 PM [View respondent's answers](#) [Add tags](#) ▼

- Dedicated pharmacy parking area
4/20/2020 2:53 PM [View respondent's answers](#) [Add tags](#) ▼

- This service could only be described as excellent. Congratulations on the initiative. It would be wonderful if this could be continued. A superior service for seniors.
5/6/2020 1:27 PM [View respondent's answers](#) [Add tags](#) ▼

- Fantastic service. Saves time and takes the stress out of trying to find a carpark , which is normally out in the back streets outside the hospital. Can't praise it enough ♥♥♥.
4/22/2020 11:27 AM [View respondent's answers](#) [Add tags](#) ▼

- Possibly be able to order online.
4/30/2020 5:48 PM [View respondent's answers](#) [Add tags](#) ▼



5. Striving for Best Practice

The primary goal of reducing potential exposure to infection for our vulnerable patients was achieved. The short feedback loop from staff and patients allowed small modifications to the drive through service to improve its operation. This and the review of the survey responses was a key driver to its overall success. One of the benefits which was underappreciated initially was the ability to manage the workflow for the pharmacists counselling patients. This was important as the pharmacists were able to make phone calls and telehealth appointments at times that there weren't high demands from hospital discharges or inpatient supply requests, improving patient flow and medication administration and safety-related workflow in other areas. Outpatient prescriptions were able to be dispensed in a scheduled manner enabling workflow to be better managed.

INNOVATION IN PRACTICE AND PROCESS

The transition from face to face consultation to telehealth and telephone consultations was a new experience for our pharmacists and patients alike. The feedback demonstrated that it was effective and well received by patients. The benefits to our pharmacists in managing workflow improved efficiency and reduced pressure at times when patients were discharging. This improved patient flow in the hospital as medicines for discharge could be prepared with less interruptions.

The existing model of patients with outpatient prescriptions being seen in the hospital as a face to face interaction has

been challenged by the changes needed in response to COVID-19. The overwhelmingly positive feedback has shown that the service has potential to operate for the long-term. The service will continue to be adapted and modified for improvement.

We have begun the credentialing process for an advance scope pharmacy assistant to provide pre-procedural medication counselling to patients.

APPLICABILITY TO OTHER SETTINGS

The drive through collection service would provide a positive patient experience irrespective of the pandemic situation. The success in utilizing technologies like telehealth counselling have demonstrated that face-to-face delivery of services isn't always necessary for routine activities. A drive through service would be applicable to other health services where 'collection' is required. This could be with home health equipment for occupational therapists or mobility support equipment from physiotherapists. The assessments could be made utilising a telehealth appointment and then the recommended aids or products could be collected via a drive through option.

The number of patients serviced via the drive through collection service highlighted the high volume of patients entering the hospital. Many of these visits could be reduced, benefiting everyone in the hospital by reducing congestion and infection transmission risk in general.



NON-CLINICAL SERVICE DELIVERY

HIGHLY COMMENDED

Western Sydney Local Health District, NSW

Auburn Hospital

Just Ask It!

Sally Henderson, Kristy Kendrigan, Riki Richards, Narelle Holden, Debbie Sharpe Lidiya Malinov and Tanja Nietlisbach

AIM

Just Ask It aimed to increase the proportion of patients who identify as Aboriginal and Torres Strait Islander patients on presentation or admission at Auburn Hospital by 50% by February 2020. We aimed to improve the welcoming environment in accordance with version 2 of the National Safety and Quality Health Service Standards and build linkages with the local Aboriginal community in order to better identify Aboriginal and Torres Strait Islander patients, to provide culturally appropriate services and care.

SUMMARY ABSTRACT

Aim: Increase identification of Aboriginal and Torres Strait Islander patients on presentation or admission at Auburn Hospital to enable better provision of culturally appropriate services and care.

Issue: During the Organisation Wide Assessment against version 2 of the National Safety and Quality Healthcare Standards (hereby National Standards) in March 2019, it was identified that Auburn Hospital did not adequately address the needs of Aboriginal and Torres Strait Islander patients. A number of areas of deficiency were identified including a lack of strategic direction, inadequate identification of Aboriginal and Torres Strait Islander patients on presentation, an unwelcoming environment for Aboriginal and Torres Strait Islander patients and a lack of engagement with the wider Aboriginal community. Whilst the Cumberland local government area (LGA) only self identifies 0.6% of its population as Aboriginal and Torres Strait Islander (Census 2016), Auburn Hospital treats patients from the wider Local Health District boundaries, areas which have higher populations of Aboriginal and Torres Strait Islanders.

Only 0.86% of patients who presented to the Emergency Department (ED) (2017-18) identified as Aboriginal and Torres Strait Islander. A welcoming environment audit conducted in June 2019 returned a compliance rate of 23%, indicating the environment did not meet the requirements of the National Standards and staff were not adequately asking the question, as demonstrated by the staff survey.

Method: An Aboriginal and Torres Strait Islander Implementation Plan was developed, encompassing a range of strategies to improve identification of, and care provided to, Aboriginal and Torres Strait Islander patients.

The welcoming environment was reviewed with an audit conducted and changes were implemented as a result. A tour of the facility was conducted with Aboriginal Community Members who identified further areas for improvement. Changes included installation of flags and maps of Indigenous Australia, availability of the Welcome to Country video on all patient entertainment system screens, installation of additional Aboriginal art works and planning for a multicultural garden to link the Aboriginal communities with other Auburn communities.

A staff survey was conducted, identifying less than 80% of staff asked new patients if they identify as Aboriginal and Torres Strait Islander and this number reduced for patients who have previously been registered. There was a lack of understanding by staff of why they ask the question, with many responding they believe it is solely related to data requirements. An education program was developed for all administrative staff who register patients, designed and run by the Western Sydney Local Health District (WSLHD) Aboriginal Training Coordinator. Training was conducted in small groups in June 2019 and included discussions and brainstorming activities, allowing participants to explore themes or questions that were identified. An observational audit was implemented to monitor change in practice.

A 48 hour follow up program was initiated by an Aboriginal identifying Nursing Unit Manager. This program enables post-discharge, culturally appropriate contact for Aboriginal and Torres Strait Islander patients to ensure their healthcare needs are continuing to be met in the community.

A formal referral pathway was implemented with the Aboriginal Maternal Infant Health Services to enable shared decision making with patients regarding antenatal care.

Results: Data indicates an upward trend in Aboriginal and Torres Strait Islander presentations to ED. There was a significant increase of 62% in the percentage of ED presentations identifying as Aboriginal and/or Torres Strait Islander from 2017-18 to 2019-20. There has been a substantial increase in referrals to the Aboriginal Liaison Officer, with an average of 2 referrals per month in 2019, increasing to an average of 9 referrals per month in 2020 (equating to four times the referrals). The Aboriginal Liaison Officer assists in ensuring patients access culturally appropriate services. There has also been improved linkages with the community through implementation of follow up

phone calls for chronic care patients, many of whom are within the Justice system, and the referral pathway with the Aboriginal Maternal Infant Health Services. These services have supported shared decision making with Aboriginal and Torres Strait Islander patients that considers culturally appropriate care and services and empowers patients to take control of their health.

There has been substantial improvement in staff asking the question for new presentations, with 100% of staff responding that they always ask the question for new patients. This has improved from 75% pre education. Observational audits of patient registrations showed an improvement from 60% compliance to 100% compliance with staff appropriately asking the questions.

Uniting War Memorial Hospital, NSW

Allied Health and Integrated Care

Wellness checks at War Memorial Hospital – connecting with our clients to prevent avoidable hospital admission and deterioration during COVID-19

Genevieve Maiden, Wendy Longley, Annabel Kingsford, Rachel Kingma, Julie Manger, Michael Fitzpatrick, Jill Hall and Lynda Elias

AIM

Despite clinical services remaining open for at-risk clients during the COVID-19 pandemic, rehabilitation clinicians at the Uniting War Memorial Hospital (UWMH) became aware of clients deteriorating in the community due to social isolation, reduced or withdrawn formal and informal supports, and reduced access to their usual health-support services including General Practitioner (GP) and specialist visits. In response to this emerging need, a multidisciplinary working group (i.e. “the project team”) at UWMH was rapidly formed to develop the “UWMH Wellness Check” care intervention. The goals of this intervention were to reduce the risk of deterioration and avoidable hospital admission for the vulnerable, elderly individuals under our care. We sought to achieve these goals by developing a new care intervention (the UWMH Wellness Check) by which staff could efficiently understand the clients’ current or emerging health and social support needs, and then effectively identify the best care and referral pathways required to alleviate any risks that were discovered.

SUMMARY ABSTRACT

As part of South Eastern Sydney Local Health District (SESLHD), Uniting WMH provides a comprehensive suite of rehabilitation services for older Australians living in the northern sector of the eastern suburbs of Sydney, with a

The welcoming environment has been re-audited after the installation of maps of Indigenous Australia, Aboriginal and Torres Strait Islander flags, the Welcome to Country on the Patient Entertainment System and installation of additional Aboriginal artworks. Compliance increased from 27% at initial audit in June 2019 to 81% in April 2020.

Qualitative feedback from Aboriginal patients has been positive, with a patient interviewed for WSLHD’s The Pulse website in relation to the Welcome to Country video. This patient stated that it was good to feel welcomed to the hospital and that she would return to the hospital again.

vision of “You are never too old to live life”. The services have an anticipatory care approach to improving individuals’ health status, preventing unnecessary hospitalisation, and preventing unnecessary injury or decline for people with acute, sub-acute, progressive and/or chronic complex health conditions. The integrated set of multidisciplinary clinical teams have a culture of collaboration, as well as strong links with the local General Practitioners (GP’s), community groups and services providers (NSQHS actions 5.5 & 5.6). The hospital is known for health promotion programs and for strategies that improve the health literacy of consumers. As Waverley Local Government Area, in which the hospital is located, was a hotspot initially in COVID, the community was very mindful of isolating early. A key part of the described project was the responsiveness, with the project commencing immediately after the social isolation directions were given to the community. Additionally, the cultural fit with the way services are provided from this hospital as part of the broader community, made the consumer uptake of the process straightforward and well accepted.

Since March 2020, COVID-19 has posed unprecedented changes in our way of life. At UWMH we are in the business of reducing isolation and loneliness for older people, despite, ironically, isolation being a key factor in reducing the spread of COVID-19. For our clients, the newly mandated isolation measures meant that their ability to access formal and informal supports and health services was greatly reduced. So, initiating a more formal structure to ensure the wellbeing of our elderly clients during the pandemic was considered a priority for clinicians and managers. A proactive and targeted approach to contacting clients where face-to-face consultations were not possible or declined by clients, was considered an urgent need. This required an agile response by the team in order to meet the needs of our clients in a timely way.

A group of key clinicians across the disciplines was rapidly brought together to form a “project team”, to address the identified new COVID-19 isolation-related care needs of our clients (NSQHS action 5.5). A review of the literature (see key papers in the reference list) and consultation among subject experts in the team and consumers enabled understanding of the specific key issues that could lead to clients’ deterioration and hospitalisation, and which should thus be a focus of consideration by the project team.

The care intervention comprised 3 parts:

- 1) A letter was developed (including feedback from consumers around its content (NSQHS actions 2.8, 2.9 and 2.10)) and sent to clients to pre-empt a phone call from our clinicians and to encourage clients to seek help for urgent needs from their GP, specialist or UWMH as required (Appendix One).
- 2) A Wellness Check questionnaire was developed, to guide consistency and efficiency with the clinicians’ phone calls to clients. The questionnaire was designed to prompt clinicians to ask about 12 specific areas of change in wellbeing that have been shown to predict heightened risk of health deterioration and hospital admission. It also included a decision making component to enable onward referral or follow up as required (Appendix Two).
- 3) The phone call wellness follow-ups were conducted in August after the initial wellness check calls had been conducted, and captured qualitative information from clients around the benefits of the calls.

Clients targeted for receiving this new care intervention were initially those considered most at risk due to isolation, or expected loss of usual in-home services. Due to the nature of UWMH’s client cohort, all clients were in the high-risk aged group (>65yo) and most would be considered to have multi-morbidities, increasing their vulnerability to COVID-19. Risk factors included living alone, those relying on regular community groups that had stopped running, those who relied on in-home care that had been temporarily suspended, and those with family whose visits had ceased due to their vulnerability. Since initial implementation of the Wellness Check phone calls, clients who were receiving care at UWMH at the time of COVID-19

outbreak, discharged from services within the last six months, or on our wait lists were added to the list of clients to be contacted (excluding those in residential aged care facilities).

Furthermore, clients identified to be at extremely high risk were offered a series of Wellness Checks in the form of monitoring phone calls at regular intervals throughout the six month period. This included clients who were declining in-home services due to COVID-19, and those with social isolation that couldn’t be addressed through other programs.

Over 1000 wellness checks calls were completed from the 16th March until 31st August by clinicians across a range of disciplines and services, reaching 474 vulnerable clients. By completing these Wellness Checks, the team were able to efficiently and successfully identify clients at risk of deterioration during this period of COVID-19 lock-down. This early identification enabled onward referral and follow up to reduce the risk of crisis or hospitalisation.

Telehealth usage has been made more accessible and generally become a more accepted way of delivering care across NSW Health, with roll out and uptake being fast tracked with the COVID-19 pandemic. It is used when clinically appropriate to provide assessment, treatment or support via virtual means for patients and families while remaining at home. UWMH were able to utilise telephone and video-conference modes to deliver these Wellness Checks, assess and appropriately triage and treat.

The Wellness Check project is an example of an innovation which aligns to the Premiers Priorities (NSW Government, 2020) of improving outpatients and community care, reducing preventable visits to hospital through caring for people in the community. By focusing on preventative healthcare in the community, the wellness checks help people stay as healthy as possible for as long as possible, while ensuring the hospital system operates efficiently and prioritises acute care resources for those who need it most.



**Royal Perth Bentley Group – East Metropolitan
Health Service, WA**

Social Work Department

Mental Health Homeless Pathways Project (MHPP)

Kat Ahlers and Carla Francis

AIM

This Project was initiated by Royal Perth Bentley Group – Mental Health Division in May 2019 to develop, build and strengthen relationships and pathways for mental health patients experiencing homelessness, and to increase knowledge and awareness across the community and government sector to create smoother pathways for this vulnerable cohort of clients .

Overall the aims of the project were to:

- Identify current RPBG MH inpatients and outpatients experiencing homelessness
- Build and strengthen pathways to stable accommodation
- Build collaborative partnerships with community organisations
- Provide staff training and education

SUMMARY ABSTRACT

Background

There is a well-established body of literature that shows individuals experiencing homelessness have a higher prevalence of chronic disease, including mental illness, than those in the general population and the economic impact on the Western Australian (WA) health system is sobering.¹ WA Health data from the 2014/15 financial year indicates that there were 31,654 inpatient days and 5,048 Emergency Department (ED) presentations for patients coded as homeless or No Fixed Address (NFA), with average length per separation three times higher than that of non-homeless patients in the same year.² This equates to a conservative cost of \$79 million to the WA health system in that year alone.³ Conversely, some of the strongest evidence around reducing hospital demand has emerged for interventions targeted specifically to those who are homeless and have chronic Mental Health (MH) issues.⁴

The prevalence of MH issues within the homeless population is extraordinary. Within a 1,070 homeless patient cohort identified over a one-year period at our hospital group, 91% had documented contact with state funded MH services. Data from the RPH Homeless Team's first 2.5 years of operations showed that 12% of their 824-patient cohort (99 individuals) had a formal diagnosis of schizophrenia, over 10x the world-wide population prevalence of 1%.⁵ However, hospital presentations for MH among homeless people is

only the tip of the iceberg; undiagnosed and under- or untreated mental illness in NFA individuals is common.

In spite of this, homeless patients in psychiatric inpatient and community mental health settings seldom have their most fundamental needs addressed, namely stable, suitable accommodation and appropriate levels of community support.⁶ Without these basics in place, good mental health cannot be achieved.

The Mental Health Homeless Pathway Project (MHPP) in Perth is working to address this gap.

The MHPP Model of Care

In May 2019, the MHPP was established to improve service delivery by the MH services of the Royal Perth Bentley Hospital Group (RPBG) for patients experiencing homelessness. The RPBG MH service comprises 92 inpatient beds over three locations, two community outpatient clinics, a specialised aboriginal MH service and a small capacity MH outreach service for rough sleepers.

Prior to the establishment of MHPP, it had been identified that 30% of inpatient (IP) MH beds in RPBG were occupied by individuals experiencing homelessness. Many repeatedly cycled in and out of the MH services. Others had long IP admissions (>28 days), occupying expensive IP beds because of a lack of any appropriate discharge options, largely related to housing.

The MHPP is run by a Project Manager with a social work background and extensive experience in community homelessness services. She liaises with members of each of the RPBG MH services to identify and assist their MH patients experiencing homelessness.

Key Elements of the MHPP

- Identify current RPBG MH inpatients and outpatients experiencing homelessness
- Build and strengthen pathways to stable accommodation
- Build collaborative partnerships with community organisations
- Provide staff training and education

The MHPP is an active participant of the 50 Lives 50 Homes Housing First Program, which to date, has permanently housed over 240 rough sleepers.⁷ By being a partner of this program, MHPP is able to refer individuals directly from the hospital to services that aim to rapidly house and provide wrap-around support to some of the most vulnerable rough sleepers in Perth.

Hospital Use

In the one-year period (from 9/5/2019 to 24/4/2020) that MHPP has been operating for, a total of 1,070 individuals with No Fixed Address were identified within RPBG. Of these, 870 had documented MH service engagement and were considered 'in scope' for this project.

Hospital use has been calculated for the first 261 patients seen by MHHPP in RPBG hospitals during a two-year period prior to the project. These 261 patients accumulated a total of 1,936 ED presentations and spent 14,119 days admitted as an inpatient in the year before the MHHPP. In WA, the average cost of an ED presentation is \$838, and each day spent in a psychiatric inpatient bed costs \$1,475.8,9 Based on these figures, for the 261 individuals they used approximately \$22.5million of hospital healthcare usage in a two-year period. If the averages for the 261 were consistent for the whole cohort of 870 in-scope individuals, this could amount to approximately \$75million in hospital use over two-years.

Why MHHPP is Needed

The WA Office of the Auditor General (OAG) reviewed the use of state funded MH services (SFMHS) from 2013-2017. Within the 212,000 cohort of SFMHS users, just 10% of individuals used 90% of all state funded MH IP bed days. This 2019 report recommended rigorous review of this high use cohort to develop alternative “pathways that enable these people to spend as much time as possible in the community and then move through more intensive services as they need to”. 11

While the OAG report did not state the proportion of these individuals experiencing homelessness, we suspect that many homeless people are in this cohort. Within RPBG data, we have already identified that homeless individuals occupy 30% of RPBG MH inpatient beds at any one time.

If homelessness in MH patients was rapidly addressed via much cheaper social inputs such as housing and supports, rather than expensive hospital care, the result would be better patient outcomes and considerably lower cost to the public purse. This situation highlights the divide between generally well-funded health services like hospitals, that are heavily impacted financially by social problems like homelessness, and the community homelessness sector which is chronically underfunded so can't address the cheaper housing and support needs of the homeless population which would reduce their healthcare usage.

Conclusion

The MHHPP is an example of a service that is

Contacts with the hospital can often be the portal through which the road to housing and recovery begins. ¹²

actively identifying and engaging with RPBG's homeless patients in their MH services. The MHHPP is attempting to link them with appropriate services upon discharge to access the accommodation and support they require. We've identified that better patient outcomes and allocation of public services could both be achieved in this high-cost patient cohort by connecting MH services to rapid access to the fundamental basics of good MH and wellness, a stable and safe place to stay and appropriate supports to stay well.



NON-CLINICAL SERVICE DELIVERY

TABLE OF SUBMISSIONS

<p>Auburn Hospital Just Ask It! <i>Kristy Kendrigan, Riki Richards, Narelle Holden, Sally Henderson, Debbie Sharpe, Lidiya Malinov, Tanja Nietlisbach</i></p>
<p>Child and Adolescent Health Service (Special Commendation Award) Child and Adolescent Mental Health CAHS Statewide Specialised Aboriginal Mental Health Service: Orienting towards an Aboriginal culturally secure service <i>Anne Wilson, Phillippa Farrell, Dion Kickett, Roger Golling, Trish Sullivan</i></p>
<p>Canberra Health Service ACT Trauma Service Prevent Alcohol and Risk-related Trauma in Youth (P.A.R.T.Y.) Program Online Initiative <i>Nardine Johnson, Beelah Bleakley, Rebekah Ogilvie</i></p>
<p>Echuca Regional Health Medical Day Treatment Unit Campaspe Cancer Support Project <i>Tracie Pearson</i></p>
<p>Royal Flying Doctor Service – Tasmania Primary Health Care Program RFDS Mobile Health Hubs <i>Cecilia Mwangi, Zoe Page, Nicole Grose, Lisa Pretorius, John Kirwan</i></p>
<p>Hornsby Ku-ring-gai Hospital Executive Unit Operational Huddles <i>Kylie Leach, Linda Davidson, Blake Edwards, Bronwyn Nolan, Samuel Ah Kit, Deb Stewart</i></p>
<p>Icon Cancer Centre Icon Cancer Service Embedding a Clinical Governance Framework into an integrated National Cancer Care provide <i>Joanne O'Shea, Ann Maguire, Renee Mc Mullen, Amanda Waldon, Kyla Snelling, Justine Morrow</i></p>
<p>International Medical Centre Pharmacy Department Waiting Time of Out Patient Pharmacy <i>Ali Saber, Basmah AlQumysh, Jamal Siddiqi, Reham Salem</i></p>
<p>Illawarra Shoalhaven Local Health District Nursing and Midwifery Directorate Your Attitude Matters: Building a Safety Culture <i>Valerie Wilson, Denise Edgar, Sarah Kalchbauer, Maree Parker, Jackie Donsante, Sharon Morgan, Bekk Middleton, Christopher Hinder</i></p>
<p>Redcliffe Hospital Pharmacy Department Drive Through Pharmacy Collections – Minimising hospital visits for vulnerable patients <i>Michael Sparqo, Ann Whitaker, Geoffrey Grima</i></p>
<p>Royal Bahrain Hospital Infection Control and Quality COVID 19 Prevention and control Strategies <i>Anal Thankappan, Tariq Almusawi, Rehana Nazir</i></p>
<p>Royal Perth Bentley Group – East Metropolitan Health Service Social Work Mental Health Homeless Pathways Project (MHPP) <i>Kat Ahlers, Carla Francis</i></p>
<p>Southern Adelaide Local Health Network Partnering With Consumers Advisory Group SALHN's Consumer Engagement Journey <i>Peter King, Fran Gallardo</i></p>

South Western Sydney Local Health District

Centre for Education and Workforce Development

Advanced Breastfeeding Program – supporting registered nurses and midwives and enrolled nurses to support Mothers and Babies in SWSLHD and beyond

*Tracey Garland, Annette Wright***South Western Sydney Local Health District**

Clinical Informatics and Clinical Governance Unit

Managing Deterioration (Between the Flags) v4 implementation – SWSLHD Clinical Informatics Approach

*Vinstein Brillante, Andrew Ingersoll, Rosemary Beenie, Nicole Morrison, Vinstein Brillante***Townsville Hospital and Health Service**

Building, Engineering and Maintenance Services

Indoor air quality and mould prevention of healthcare facilities in the tropics

*Mark Fasiolo, Michael Ward***Uniting War Memorial Hospital**

Allied Health and Integrated Care

Wellness checks at War Memorial Hospital – connecting with our clients to prevent avoidable hospital admission and deterioration during COVID-19

*Genevieve Maiden, Wendy Longley, Annabel Kingsford, Rachel Kingma, Julie Manger, Michael Fitzpatrick, Jill Hall, Lynda Elias***Auburn Hospital**

Co-designing sustainable partnership between consumers and staff at Auburn Hospital

*Coralie Wales, Tara Lee, Alicia Wood, Katy Scrivens, Debbie Sharpe, Sally Henderson, Riki Richards, Tanja Nietlisbach***Sydney Dental Hospital and Oral Health Services, SLHD**

COHIS

Improving the consumer experience and accessibility to Oral Health Service using an innovative IVR system

*Poonam Kapoor, Rhodora Evangelista, Shilpi Ajwani, Silvia Park***Sydney Local Health District**

Biomedical Engineering

BME (Biomedical Engineering) UVC Germicidal Unit

Meenal Sharma, Chin Voon, Donald Hazra

HEALTHCARE MEASUREMENT

WINNER

Metro North Hospital and Health Service, QLD

Clinical Governance, Safety, Quality and Risk

Using Hospital Acquired Complication Data to Improve Patient Outcomes

Mark Butterworth, Craig Draper, Nicole Pearson, Michelle Marshman and Sarah Cake

AIM

The second objective of the Metro North Hospital & Health Service (MNHHS) Strategic Plan 2020-2024 focuses on improving health equity, access, quality, safety and health outcomes. The entire Health Service was engaged to reduce Hospital Acquired Complications not present on admission from our 2018 number of 9,850.

SUMMARY ABSTRACT

A Hospital Acquired Complication (HAC) is a complication that was not present on a patient's admission to hospital and may have been prevented by clinical risk mitigation. HACs result in harm to the patient, affect a patient's recovery, can result in longer length of stay in hospital, increase a patient's hospital admission costs and divert hospital resources away from other patient care activities.

The National HAC list includes 16 agreed high-priority complication groups, with HAC identification reliant on ICD codes and the condition onset flag (which identifies a complication as "present on admission" and not hospital acquired) in the admitted data collection.

Metro North in July 2018 introduced a range of system wide strategies to reduce the number of HACs from both technical (accurate coding) and clinical perspectives including:

- HACs were to be monitored by Clinical Directorates through a purpose-built Metro North HAC Dashboard.
- A report was developed for Metro North hospitals using benchmarked data published by the Health Roundtable (HRT) to identify good performance relative to each hospital's peer group and areas for further improvement.
- Clinical governance committees established to identify, manage, monitor, review and escalate clinical incidents and risks, added incidents specifically related to HACs to their agendas.
- Clinical governance committees also identified and shared the strategies and initiatives implemented

across Metro North to reduce HACs and improve patient care.

- Review of the accuracy of clinical coding and improvements were made in the early identification by clinicians of complications that were not acquired within a Metro North healthcare facility.
- Policies, procedures, clinical practice and local guidelines, flowcharts, management plans, screening and assessment tools were reviewed to ensure healthcare workers identified patients at specific risk of healthcare associated complications.
- All Clinical Directorates identified, developed prevention and management strategies to coordinate healthcare needs for patients identified as 'at risk' of complications such as pressure injuries, falls, malnutrition and delirium.
- Line managers committed to review both clinical incidents and HACs within their area and variances and risks were to be reported to the respective clinical governance committee.

In 2018/19 there were 6,413 HACs recorded, a 35% decrease on the previous year where 9,850 HACs were identified. 5,471 patients had one or more HACs in 2018/19, this is 26% fewer patients than the previous year.

In every reportable HAC element MNHHS reduced the number of hospital acquired complications by up to 77% in the case of persistent incontinence.

The reduction in HACs has contributed positively to service delivery. The decline in HACs has reduced costs associated with treating patients with HACs (the average length of stay for an inpatient in MNHHS with a HAC is approximately 16 days compared to approximately 3 days for inpatients without a HAC) and enabled the redirection of resources from treating patients with hospital acquired complications to treating additional patients.



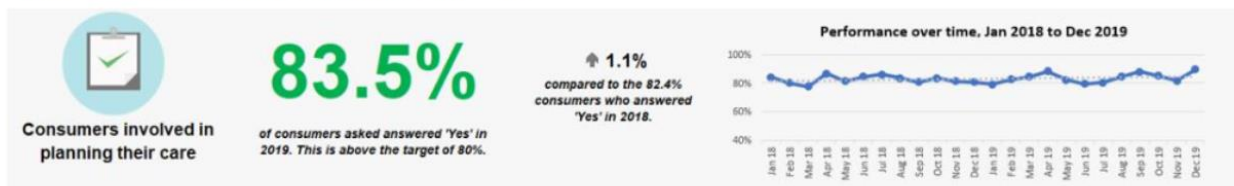
REPORT

APPLICATION OF ACHS PRINCIPLES

1. Consumer Focus

Consumers provide valuable feedback on their experience which assists clinical services to better meet the needs of the community we serve. This has been reflected particularly in the Partnering with Consumers data compiled from the MNHHS Clinical Weekly Audits below.

Graph 1 – Consumers involved in planning their care



On average the target KPI (80%) was met by Metro North over a 24month period.

Graph 2 – Staff have spoken to consumers about their treatment plan of care



Metro North results remain, on average, above the target KPI 90%. The last 5 data collection points (August – December 2019) are consistently above the 95th percentile.

Consumers also contributed to Metro North’s Clinical Governance through participation as members of Health Service wide ACHS Standard and Clinical Directorate committees.

2. Effective Leadership

Clinicians are responsible for delivery of patient-centred, safe and effective care and are actively engaged in safety and quality activities at each level of the organisation. Clinicians, including clinician managers and directors, lead the review and management of performance metrics, audits, morbidity and mortality reviews, consumer feedback and clinical outcomes.

In July 2018 Metro North HHS introduced a range of system wide strategies to reduce the number of HACs from both technical (accurate coding) and clinical perspectives including:

- HACs were to be monitored by Clinical Directorates through a purpose-built Metro North HAC Dashboard.
- A report was developed for Metro North hospitals using benchmarked data published by the Health Roundtable (HRT) to identify good performance relative to each hospital’s peer group and areas for further improvement.
- Clinical governance committees established to identify, manage, monitor, review and escalate clinical incidents and risks, added incidents related to HACs to their agendas.
- Clinical governance committees also identified the strategies and initiatives implemented across Metro North to reduce HACs and improve patient care.
- Review of the accuracy of clinical coding and improvements made in the early identification by clinicians of complications that were not acquired within a Metro North healthcare facility.
- Policies, procedures, clinical practice and local guidelines, flowcharts, management plans, screening and assessment tools were reviewed to ensure healthcare workers identified patients at specific risk of healthcare associated complications.
- All Clinical Directorates identified, developed prevention and management strategies to coordinate healthcare needs for patients identified as ‘at risk’ of complications such as pressure injuries, falls, malnutrition and delirium.

- Line managers committed to review both clinical incidents and HACs within their area and variances

and risks were to be reported to the respective clinical governance committee.

3. Continuous Improvement

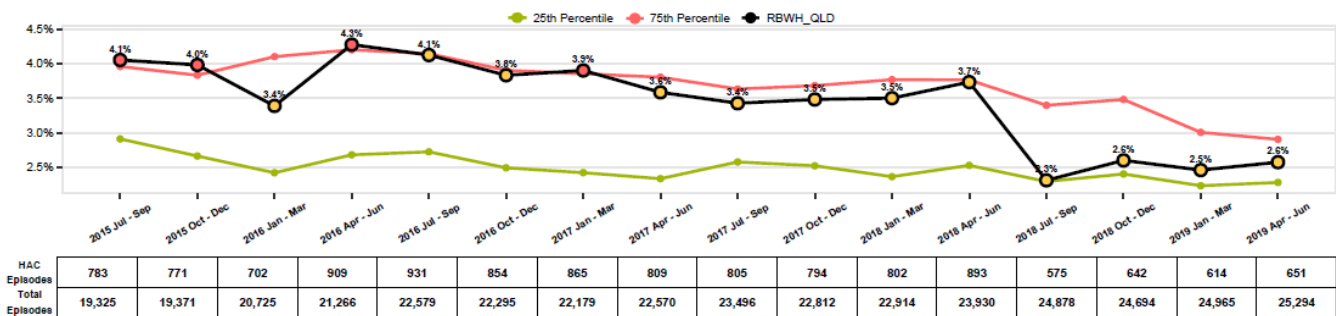
Four Year Benchmarked Trends

The Health Roundtables provides four year HAC trend charts that are benchmarked against each hospital’s peer group. The benchmarking uses percentiles to show relative performance. Percentiles are used to indicate the value below which a given percentage of the peer hospitals in a group of peer hospitals falls. For example, the 25th percentile is the value below which 25% of the hospitals may be found. Therefore, with a low HAC value representing good performance, a value at or below the 25th percentile would put a hospital’s performance within the best 25% of its peer group. Conversely, a value above the 75th percentile would put a hospital’s performance within the poorest performing 25% of its peer group.

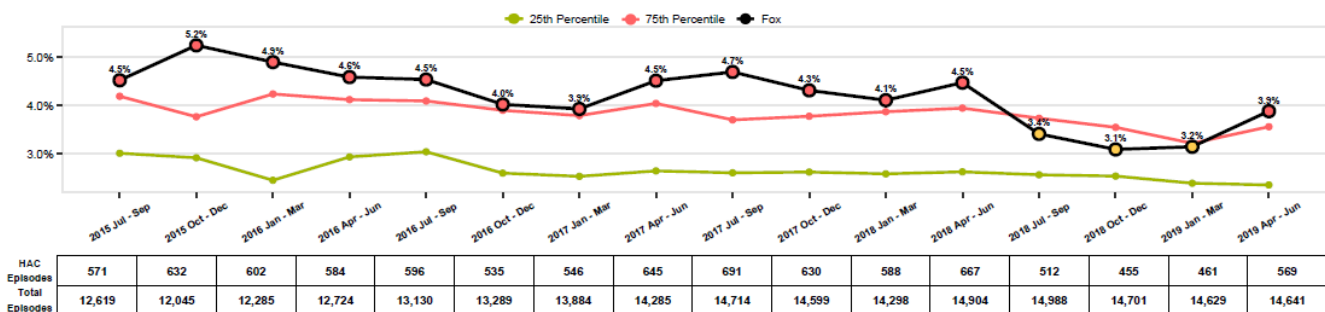
The below charts show that all Metro North facilities reduced the total number of HACs from the beginning of 2018/19. Whilst Caboolture and Redcliffe had been around or below the 25th percentile for some time, Royal Brisbane & Women’s Hospital (RBWH) had the most substantial reduction. The Prince Charles Hospital (TPCH) also improved performance from July 2018, declining to within the 75th percentile which was sustained for three of the four quarters. The Health Roundtable data also shows that the areas TPCH compares least favourably compared to its peers are respiratory complications, renal complications and cardiac complications. It should be noted that TPCH’s peer group are similar sized hospitals that do not necessarily have large Heart and Lung centres like TPCH.

Health Roundtable Four Year Total HAC Trend by Hospital to June 30 2019

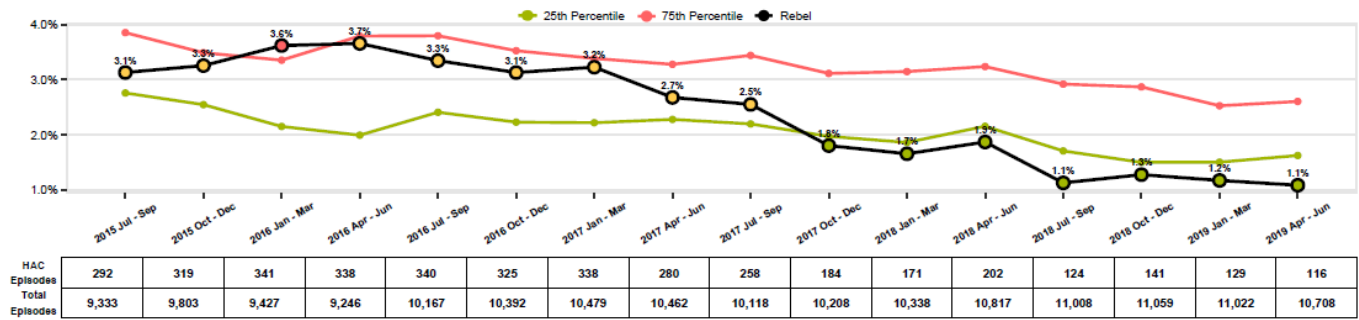
RBWH



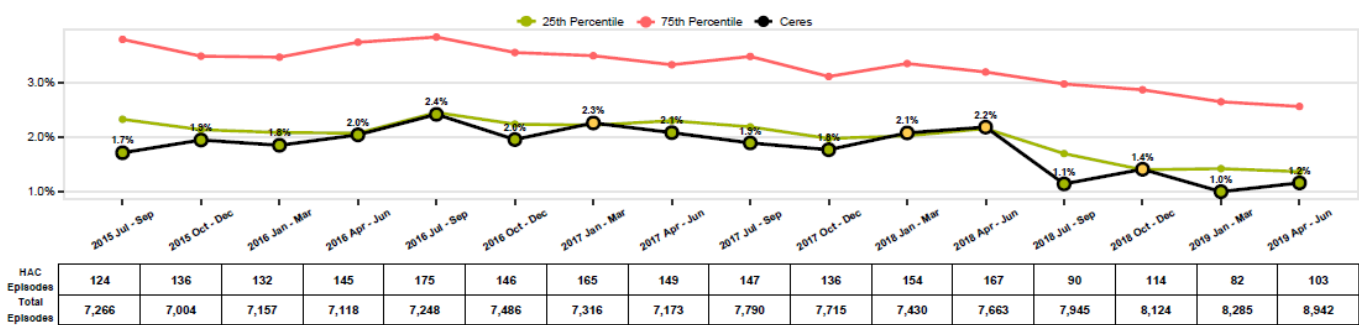
TPCH



Redcliffe



Caboolture



HRT data for Kilcoy hospital is not collected
 Source: Health Roundtable, Hospital-Acquired Complications Report, Jul 2018 – Jun 2019



Evidence of Outcomes

Table 1: Number of Hospital Acquired Complications by complication 2017-18 and 2018-19

Complication	% Final incremental cost adjustment ¹	2017-18 ²	2018-19 ²	# Movement	% Improvement ³
All HACs	8.8%				
1. Pressure Injury	14.3%	79	42	-37	47%
2. Falls resulting in fracture or other intracranial injury	2.5%	77	53	-24	31%
3. Healthcare associated infection	9.0%	3,011	2,033	-978	32%
4. Surgical complications requiring unplanned return to theatre ⁴	14.2%				
5. Unplanned intensive care unit admission ^{4,5}	n/a				
6. Respiratory complications	18.3%	802	674	-128	16%
7. Venous thromboembolism	13.0%	266	200	-66	25%
8. Renal failure	27.0%	79	66	-13	16%
9. Gastrointestinal bleeding	10.7%	372	188	-184	49%
10. Medication complications	8.7%	730	498	-232	32%
11. Delirium	10.2%	1,616	986	-630	39%
12. Persistent incontinence	2.6%	229	53	-176	77%
13. Malnutrition	6.7%	178	78	-100	56%
14. Cardiac complications	11.8%	2,191	1,342	-849	39%
15. Third and fourth degree perineal laceration during delivery ⁵	n/a	183	165	-18	10%
16. Neonatal birth trauma ⁵	n/a	37	35	-2	5%
Total		9,850	6,413	-3,437	35%

Notes:

1. Source 'Final incremental cost adjustment' applied to 2018-19, from Pricing and funding for safety and quality: Risk adjustment model for Hospital Acquired Complications, Version 3, March 2018, IHPA.
2. Source 2017/18 and 2018/19 HACs from SPR Metro North HHS Performance Report, July 2019, GENWAU data 13/08/2019.
3. All Complications improved (decreased). However, % Improvement data are colour coded based on the cell's value, from lowest value (red) below midpoint (50th percentile) (orange) to highest value (green) above midpoint. That is, red = lowest % improvement through to green = highest % improvement.
4. ACSQHC HAC specifications V1.1 - August 2018 notes Complications 4 and 5 are not currently collected in administrative data. Data elements may be collected locally, specifications available on METeOR.
5. No financial HAC adjustment currently applies.

Surgical complications requiring unplanned return to theatre is reported locally and only had a reduction of one case down from 340 in 2017/18 compared to 339 returns in 2018/19 across MNHHS.

4. Striving for Best Practice

Attachment 1. Contains the benchmarked performance and improvement initiatives for each MNHHS wide HAC. Below is a sample of the performance benchmarking and initiatives of one HAC, provided as an example.

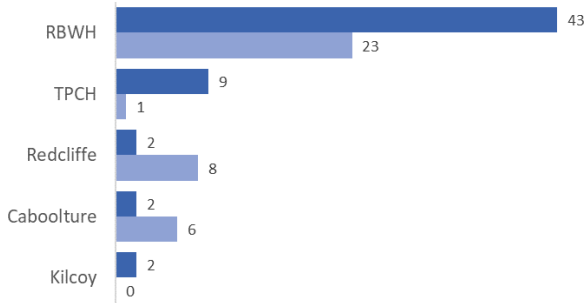
Pressure injury

Pressure injury HAC episodes declined by 34% in 2018/19 to 38 while the NWAU adjustment declined by 65%. Pressure injury HACs are the joint 10th most prevalent HAC group and accounted for less than 1% of Metro North's NWAU

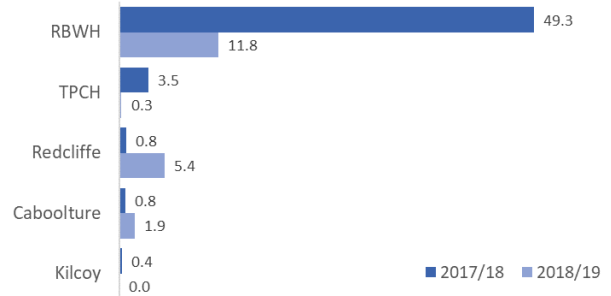
adjustment. RBWH has substantially reduced pressure injuries over the last financial year and Health Round table benchmarked data for Pressure injury per 10,000 episodes shows a declining trend for RBWH with Q4 2018/19 performance only slightly above the 25th percentile. Despite a small increase in pressure injuries at Redcliffe and Caboolture, Redcliffe was within the 25th percentile for its peer group while Caboolture was at the 50th percentile. TPCH has consistently performed well against its peers and was within the 25th percentile for 2018/19.

**Metro North Annual Comparison of Performance
Pressure injury**

HAC Episodes by Facility 2017/18 – 2018/19



NWAU Adjustment by Facility 2017/18 – 2018/19

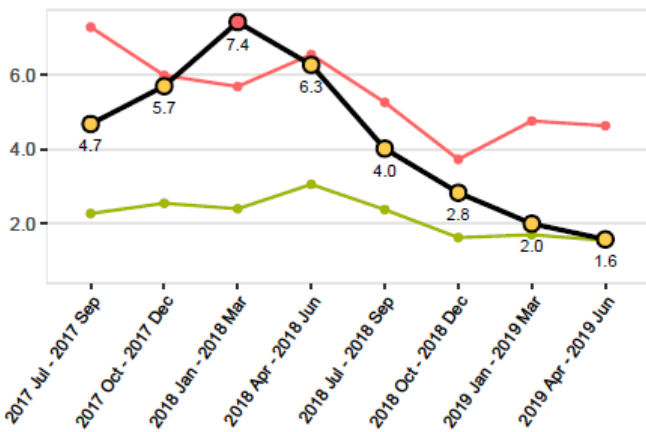


Source: DSS, downloaded 30/09/2019

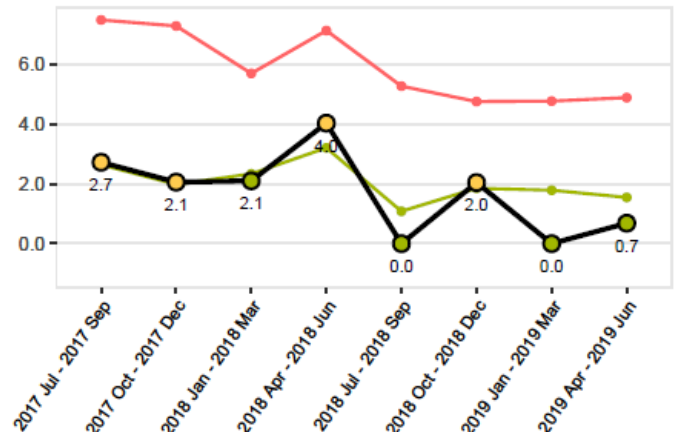
**HRT Trended Peer Comparison (Quarterly) July 2017 – June 2019
Pressure injury per 10,000 episodes**

25th Percentile 75th Percentile

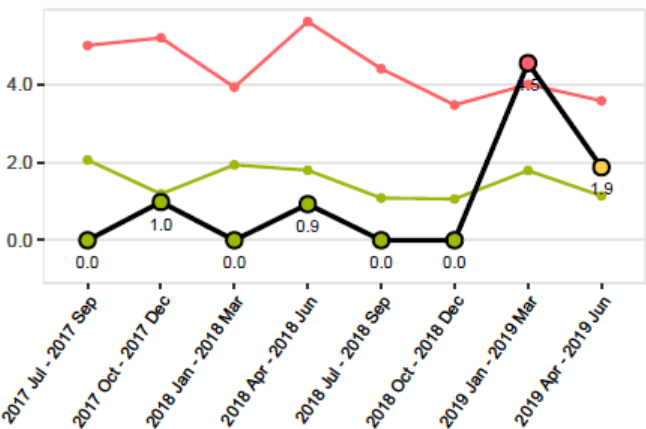
RBWH



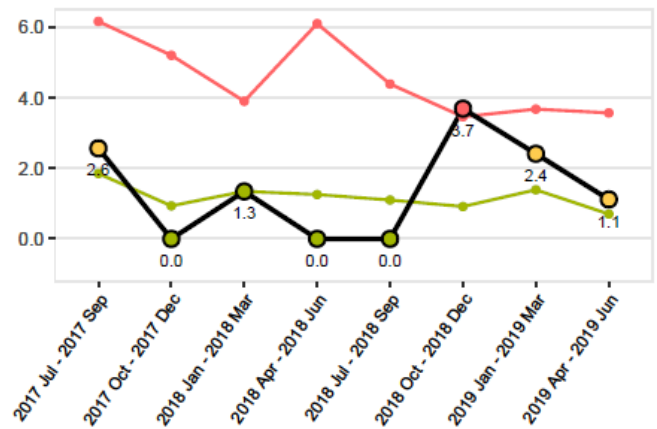
TPCH



Redcliffe



Caboolture



Source: Health Roundtable, Hospital-Acquired Complications Report, Jul 2018 – Jun 2019

Strategies and initiatives to reduce rates of pressure injury

- Policies, procedures, clinical practice and local guidelines, flowcharts, management plans,

screening and assessment tools are in place for healthcare workers to identify patients at specific risk of pressure injuries.



- All Clinical Directorates apply prevention and management strategies to coordinate healthcare needs for patients identified as 'at risk' of pressure injury.
- Clinical governance committees (pressure injury prevention and management committee) are in place to identify, manage, monitor, review and prioritise risks.
- Metro North Skin Integrity Dashboard provides high level visibility of hospital performance related to skin integrity data and pressure injury data recorded in the RiskMan system for Executives and Service Line Leaders.
- The ongoing pressure injury prevention and management is included on individualised ward quality improvement plans. Action plans have been developed in some Clinical Directorates. All cases undergo a formal chart review.
- As a result of a pilot study which identified that several mattresses were failing compression tests, RBWH undertook a facility wide audit of foam mattresses and implemented a mattress replacement process.
- Caboolture Hospital has produced a pressure injury prevention video for consumers, which is provided to them on iPads.
- Redcliffe Hospital has implemented a hospital wide improvement plan for the prevention of pressure injuries, which includes a thorough review of each clinical case, shared learnings and a hospital wide education plan to refresh processes for comprehensive skin assessments, pressure injury staging and pressure injury management.
- TPC Health Information Services Team works closely with clinical staff to reconcile Pressure Injury details reported against RiskMan and Clinical Coding Data to ensure accurate reporting of pressure injuries.
- RBWH Health Information Services Team has worked with clinicians to reduce unspecified pressure injuries as this was the main area identified for improvement around documentation practices.

INNOVATION IN PRACTICE AND PROCESS

The innovations and strategies used to deliver the 35% improvement in HACs are included in Section C Striving for best Practice and in Attachment 1.

APPLICABILITY TO OTHER SETTINGS

Whilst the HAC learning of hospital have been shared within MNHHS and some across Queensland the principles and initiatives are likely applicable to any health service.

REFERENCES

Safer care saves money: How to improve patient care and save public money at the same time, Grattan Institute, August 2018.

Pricing and funding for safety and quality: Risk adjustment model for Hospital Acquired Complications, Version 3, March 2018, Independent Hospital Pricing Authority (IHPA)

Hospital-Acquired Complications Information Kit, Australian Commission on Safety and Quality in Health Care.



HEALTHCARE MEASUREMENT

HIGHLY COMMENDED

Bolton Clarke, QLD

Care, Innovation and Quality team

Developing Clinical Outcome Indicators applicable to a home nursing environment*Janet Pugh and Tracy Ayles*

AIM

To develop a suite of clinical outcome indicators (COIs) for the home-based nursing setting, derivable from the electronic client information management system (Procura) and with a focus on achieving future benchmarking.

ABSTRACT SUMMARY

Method:

Bolton Clarke Senior Clinical Nurse Advisors (SCNA), Clinical Quality & Risk Managers (CQRM), the Clinical Governance team, the the Procura team and the Information Services (IS) teams, developed the nine COIs. These are gathered directly from preexisting Procura clinical information. Initially, the Procura software rollout did not include client goal setting and care planning due to business constraints, however these components are now being developed. Selection criteria for COIs were content validity, face validity and the feasibility for collecting data using current systems. The focus was to establish a suite of outcome indicators to add to the quality indicators based on process and structure in use and to provide another quality check for clinical care.

Findings:

Due to the absence of software-based goal setting and care planning, the approach to setting COIs needed

adjustment and rethinking. Collecting data manually by retrospective chart audit was not sustainable due to resource requirements including staffing and costs. Key areas of clinical care identified through client data determined the priorities for suitable outcome indicators, considering the clinical relevance, feasibility of collection and the potential for updating once a fully electronic client record system was in place. Outcome indicators were selected to cover general health and for specific health conditions.

When it was not possible to develop a full COI at this point, without access to a full electronic record, the interim step of a process indicator that could still inform quality care was utilised. This means that the current outcome indicators have been launched with the intent of using a 'plan, do study and act' cycle of review, allowing further development as resources and systems allow.

Outcomes:

By working together, identifying gaps and restraints impeding development, and taking an evidence-based flexible approach, it has been possible to develop a practical and clinically useful set of COIs. Overall health markers such as malnutrition, weight loss or unplanned acute care admission are systematically reviewed, the organisation can track progress against expected performance targets and deeper analysis provides individual client benefits through referral back to local clinical teams for review and feedback. This substantially improves our clinical quality monitoring capacity. Further work to integrate the two process indicators into the suite of outcome indicators is planned. Wider publication of the work is being sought, so that external benchmarking with similar organisations and better service provision information for potential clients can occur in the future.



Townsville Hospital and Health Service, QLD**Healthcare Standards****Sustained reduction in Wrong Blood in Tube incidents
at Townsville University Hospital***Natalie Shiells, John Casey, Neil Silvester and Jody
Gallagher***AIM**

To achieve a sustained reduction in Wrong Blood in Tube incidents at Townsville University Hospital using the positive patient identification functionality within the integrated electronic Medical Record, to reduce the risk of delayed treatment, adverse transfusion outcomes and unnecessary specimen recollection.

SUMMARY ABSTRACT**Introduction:**

There are critical implications for preanalytical errors in venipuncture. Wrong Blood in Tube is defined as 'blood samples that are different from that of the patient whose name is on the label' (Oldham 2014), and has been an Organisational priority due to the inherent risk of devastating patient outcomes such as failure to communicate critical results, missed or delayed diagnosis, inappropriate treatment regimens, and ABO incompatibility related to blood transfusion (Kemp, Bird & Barth, 2012).

Mislabeled blood specimens continue to be a significant problem, with human factors evidently being attributed to the root cause of these errors (US National Library of Medicine and National Institutes of Health 2015) despite being a critical component of accurate patient identification.

Objectives:

To implement a sustained reduction in Wrong Blood in Tube incidents at Townsville University Hospital using the positive patient identification functionality within the integrated electronic Medical Record to reduce the risk of adverse patient outcomes.

Methods:

Between 1 February 2019 and 31 March 2019, CNC Haemovigilance and the Quality Manager for Pathology Queensland (Townsville) collected and analysed local wrong blood in tube data to gain a better understanding of the clinical issues behind mislabeled specimens. It was determined that overriding the scanning function in the integrated electronic Medical Record to confirm

patient identification, pre-printing of specimen labels and having an alternative patient's chart opened in the ieMR were the primary reasons behind preanalytical errors.

A review of the integrated electronic Medical Record clinician training provided prior to go live, revealed that due to the lack of availability of scanners in the training domain, clinicians were instructed to follow the 'override' function when practicing specimen collection, and continued to use this function following the go live period, which evidently was the core of the compliance issues related to scanning. However, while computerized systems have proven in-built patient safety functionality, it can only be relied on as a patient safety measure when the system is used for its intent by clinicians (Kemp, Bird & Barth 2012). Patient variables, equipment, workforce and culture were also considered during the investigative phase of this initiative, acknowledging that factors such as restricted availability of computers and printers and the management of confused, aggressive or infectious patients impact the ability to perform the scanning function during specimen collection.

The positive patient identification reporting functionality within the integrated electronic Medical Record enabled the CNC Haemovigilance to develop, refine and distribute a monthly compliance report to each Service Group within Townsville University Hospital. The report promoted awareness of the scanning functionality within the integrated electronic Medical Record, identified any clinical issues that may prevent the scanning process from occurring and highlighted the implications of omitting the use of the in-built patient safety functionality.

Results:

The incidence of wrong blood in tube decreased from 0.068% to 0.05% over a 12-month period, with the absolute number of wrong blood in tube incidents reducing from 175 over the 2018/2019 period to 132 in 2019/2020. The monthly average for wrong blood in tube prior to implementation of this initiative was 14.6 in 2018/2019 compared to a reduced average of 11.0 for 2019/2020, with the total number of specimens collected comparable between the two reporting periods, with 257,507 specimens collected in 2018/2019 and 258,759 specimens collected in 2019/2020.

Conclusion:

Blood sampling is historically an error prone event, however while there is an abundance of issues influencing the compliance with positive patient identification, human factors are an inevitable



contributor to incorrect specimen labelling. Removing human factors entirely is unrealistic, therefore developing an understanding of the contributing influences to human error and leading culture change is essential in developing interventions to improve patient safety.

As Townsville University Hospital is a digital hospital, patients are provided with unique bar code identifiers on their armbands for accurate patient identification and added patient safety, however although the introduction of new systems requires an adjustment to clinical practice, it was concerning that the scanning

process during specimen collection is repeatedly being overridden.

Ultimately, workplace culture is an influential factor in compliance with patient safety processes, therefore by using an organisation wide approach to monitoring, managing and reviewing Wrong Blood in Tube discrepancies, the opportunity for error has reduced. The concept behind this initiative is applicable to other functionalities within the integrated electronic Medical Record, such as medication administration, and can be applied to all digital health services to improve the provision of safety and quality to consumers.



HEALTHCARE MEASUREMENT

TABLE OF SUBMISSIONS

<p>Blacktown Mount Druiitt Hospitals, Western Sydney Local Health District Pharmacy and Digital Health Solutions 'Dispensing with' paper: Australian-first implementation of e-discharge scripts <i>Amy Murray, Liz Ellankil, Stuart Binns, Lucy Lin, Shehzad Munir</i></p>
<p>Bathurst Health Service (Western NSW LHD) Emergency Department Improving the safe accelerated discharge of low risk chest pain from a regional emergency department during the COVID-19 pandemic <i>Alice Leung, Mithila Zaheen, Pavan Phanindra</i></p>
<p>Townsville Hospital and Health Service Healthcare Standards Sustained reduction in Wrong Blood in Tube incidents at Townsville University Hospital <i>Natalie Shiells, John Casey, Neil Silvester, Jody Gallagher</i></p>
<p>Bolton Clarke Care, Innovation and Quality team Developing Clinical Outcome Indicators applicable to a home nursing environment <i>Janet Pugh, Tracy Aylen</i></p>
<p>Canberra Health Service Division of Mental Health, Justice Health, Alcohol and Drug Services Improving the physical health of people living with serious mental illness using a quality improvement collaborative approach. <i>Nicola Champion, Llew Lewis, Stephanie Burvill, Toni Cooper, Sonia Res, Manju Shine, Daniela Pena, Jenny Fothergill</i></p>
<p>Central Adelaide Local Health Network (CALHN) Clinical Governance – Safety, Quality & Risk Management Unit #TowardsZeroHarm: Improving Patient Safety by reducing our Hospital Acquired Complications (HACs) <i>Rose Ercolino, Kathryn Zeitz</i></p>
<p>Far West Local Health District Clinical Governance Unit Far West Local Health District's (FWLHD) Zero Falls Redesign Project <i>Rekha Pillai, Linda Sutherland, Dale Sutton</i></p>
<p>Hong Kong Baptist Hospital Infection Control Unit A multi-strategy approach with the participation of Infection Control Link Nurse (ICLN) to enhance staff influenza vaccination rate and overcome campaign fatigue <i>Cindy Wong Yin Yin, Alex Yu Wai Yin, David Lam Tat Yin, Patrick Lau Pak Lun, Victor Lee Ching Kong, Grace Wong Yuen Ling, Susanna Lee Wai Yee, Huang Ching Ching</i></p>
<p>Hunter New England Local Health District (Special Commendation Award) Aboriginal Health Unit Defining the Gap: A Planning and Reporting Framework for Closing the Gap <i>Aimee Smith, Stacey Simpson</i></p>
<p>Metro North Hospital and Health Service Clinical Governance, Safety, Quality and Risk Using Hospital Acquired Complication Data to Improve Patient Outcomes <i>Mark Butterworth, Craig Draper, Nicole Pearson, Michelle Marshman, Sarah Cake</i></p>
<p>Royal North Shore Hospital Patient Safety and Quality Unit Managing by Fact: From Bedside to Boardroom <i>Helen Ganley, Valerie Elsmore, Katerina Angstrom, Philip Hoyle, Alison Zecchin</i></p>
<p>Palliative Care South East Clinical Services Sustaining Improvement in Timely Access to Specialist Palliative Care Services <i>Jodi Lynch, Kelly Rogerson, Julie Murphy, Joy Jarratt, Robyn Scott, Chris Lean, Sam Stubbs</i></p>
<p>Perth Children's Hospital (PCH)</p>

<p>Child and Adolescent Health Service (CAHS) Improving the care of adolescents admitted to hospital with an Eating Disorder <i>Joanne Siffleet, Kara Edwards, Rachel Newton, Sue Baker, Andrew Martin, Linda Hop, Amanda Newell, Sarah Skeldon</i></p>
<p>Peel Health Campus Reducing the Rate of Apgar Scores of less than 7 at 5 minutes in Term Neonates <i>Wendy Allan, Leanne Rendell, Maria Berryman</i></p>
<p>The Royal Children's Hospital Melbourne EMR Project Team Workflow efficiencies via electronic medical record optimisation in a tertiary paediatric burns clinic <i>Daryl R. Cheng, Sharman P. Tan Tanny, Rebecca P. Hsu, Warwick J. Teague, Diana Truong</i></p>
<p>Women's and Children's Health Network Women's and Babies Division The Preventing Perinatal Brain Injury in Preterm Infants (PINI) Initiative <i>Amy Keir, Charlotte Groves, Angela Cavallaro, Fiona Margrie, Alice Rumbold</i></p>
<p>Campbelltown Hospital Physiotherapy Department A new clinical incident management process within the physiotherapy Department and Camden and Campbelltown Hospital for the prevention of clinical incidents <i>Lukas Szymanke, Monique Boulos, Sharmane Motuliki, Stephanie Taylor, Jason Foo</i></p>
<p>Liverpool Cancer Therapy Centre, Liverpool Hospital Department of Medical Oncology Reducing Polypharmacy and the Use of Low or Limited Value Medications in Patients with Advanced Cancer <i>Sana Haider, Wei Chua, Joseph Descallar, Eugene Moylan</i></p>
<p>Townsville Hospital and Health Service Infection Prevention and Control THHS Sustained Reduction in SABs <i>Janine Carrucan</i></p>
<p>Hong Kong University Shenzhen Hospital Medical Imaging Centre Reduction of Door to Wire time for patients with ST-elevation Myocardial Infarction to improve clinical outcomes <i>Yiu Kai Hang, Hu Xiao Ming, Chen Bo, Wu Min, Chen Hong Da, Wang Run, Cao Gao Zhen</i></p>
<p>Hong Kong University Shenzhen Hospital Clinical Oncology Centre Advocacy to provide good quality oncology services during the COVID-19 pandemic <i>A.W.M. Lee, Xu Zhiyuan, Hui Siu Kee Tim, Dong Fule</i></p>



GLOBAL QUALITY IMPROVEMENT

WINNER

Hong Kong University Shenzhen Hospital, China

Medical Imaging Centre

Reduction of Door to Wire time for patients with ST-elevation Myocardial Infarction to improve clinical outcomes

Yiu Kai Hang, Hu Xiao Ming, Chen Bo, Wu Min, Chen Hong Da, Wang Run and Cao Gao Zhen

AIM

Our aim is:

1. To build a professional cardiac interventional team up to an international advanced level, comprising experienced doctors, nurses and technical staff from the A&E Department and Pre-hospital Emergency Team, Radiology and Imaging (Digital Subtraction Angiography) Department and Interventional Cardiology Department;
2. Shortened the average DTW time to within 60 minutes;
3. Optimizing the diagnosis and treatment processes;
4. Improving the team competence and capabilities in cardiac interventional procedures.

SUMMARY ABSTRACT

ST-elevation Myocardial Infarction (STEMI) is the most serious type of coronary heart disease which has the characteristics of rapid morbidity and changes in the state of the illness. The main therapeutic method for STEMI patients is Percutaneous Coronary Intervention (PCI). [1] Through puncturing the patient's radial artery or femoral artery, the wire (W) is threaded into the coronary artery, and the stent is released through the balloon (B) to open up the diseased vessel. Since PCI can be used efficaciously to relieve symptoms of coronary heart disease, the mortality rate of coronary artery disease patients will be lowered with better clinical prognosis. [2]

DTW (Door to Wire) time (which is shorter than Door to Balloon DTB time) is being used as one of the key evaluation criteria to assess whether a Chest Pain Centre in China can be accredited and designated as a China National Chest Pain Centre (CNCPC). To be so designated, the DTW time should be under 90 minutes.

To improve our ability in treating acute cardiovascular disease patients and become a national chest pain centre, the University of Hong Kong-Shenzhen Hospital started a CQI program to "Reduce the average DTW time for STEMI patients". From 1/1/2018 to 31/12/2018, our average DTW time was 113 minutes,

which did not meet the accreditation criteria for CNCPC. With the aim to shorten DTW time, we analyzed our patient data, draw Ishikawa diagram and continually embark on the Plan-Do-Check-Act (PDCA) cycle (Appendix I). From 1/1/2019 to 31/12/2019, our average DTW time had been reduced to 84 minutes.

The result has reached the qualification of the China Chest Pain Center, but it was just a beginning for our program. We build a professional cardiac interventional team up to an international advanced level, comprising experienced doctors, nurses and technical staff from the A&E Department and Pre-hospital Emergency Team, Radiology and Imaging (Digital Subtraction Angiography) Department and Interventional Cardiology Department.

In December 2018, our Chest Pain Centre was assessed by the Guangdong Chest Pain Centre and was officially accredited as a Provincial Chest Pain Centre.

In March 2020, our Chest Pain Centre passed the assessment and was officially accredited as a National Chest Pain Centre.

REPORT

APPLICATION OF ACHS PRINCIPLES

1. Consumer Focus

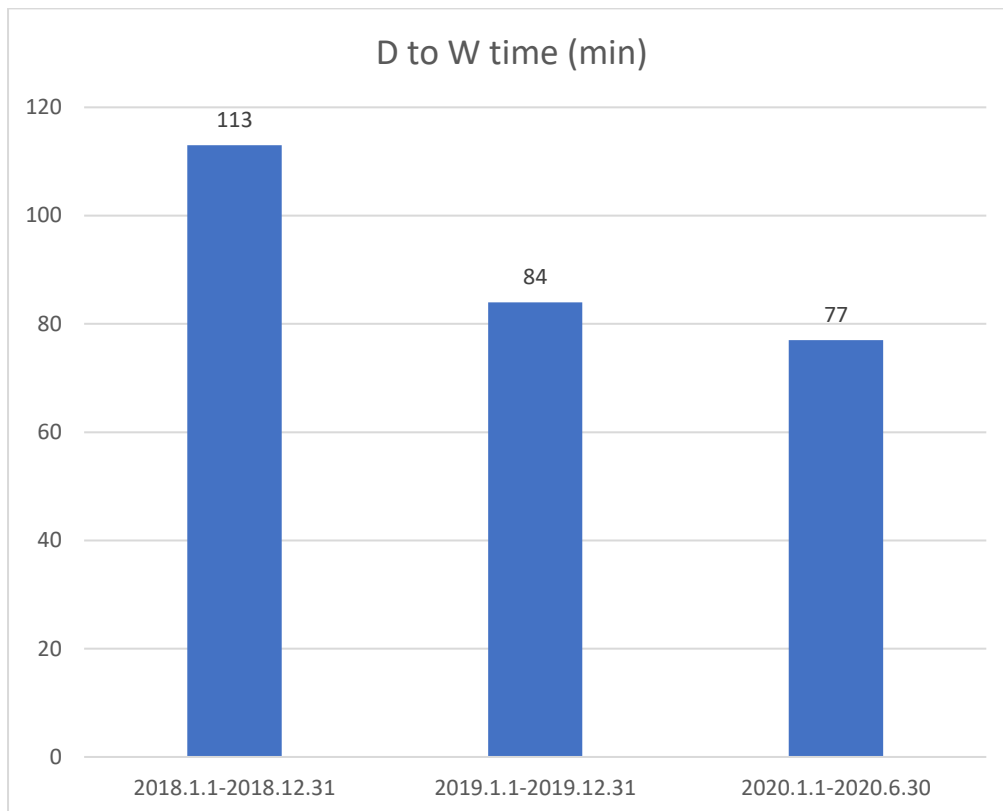
HKU-SZH focuses on patients and carers needs and participation in the planning, delivery and evaluation of the healthcare services. We following up the patients and constructing the satisfaction survey. The report of patients' degree of satisfaction became better annually, for 2018 the result was 97.5%, for 2019 the result was 98.4%. Until June 31st 2020, the result was 98.5%. Building the Green Channel, acute chest pain patients can directly enter the intervention operation room instead of first arrive at the Emergency Department and CCU Charging after treatment for the STEMI patients.

2. Effective Leadership

The HKU-SZH demonstrates effective leadership to pioneer healthcare reforms and continually improve its services. We build a professional medical team, which consists of experienced doctors and nurses from Digital Subtraction Angiography (DSA) Department, A&E, and Pre-hospital Emergency. In order to reach an international advanced level, decrease the mortality rate of STEMI patients and increase the prognosis effect.

3. Continuous Improvement

As the continued quality improvement, from January 1st 2020 to June 30th 2020, the hospital's average DTW time had been reduced to 77 minutes, the rate of reduction is 8.33%.



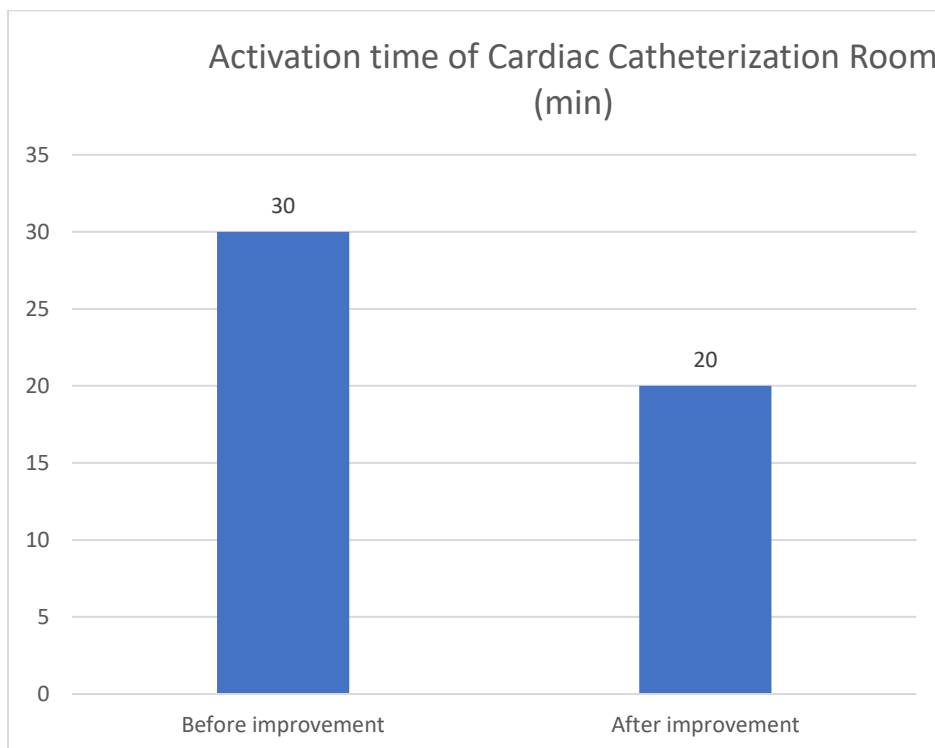
4. Evidence of Outcomes

1. From 1/1/2020 to 30/6/2020, our average DTW time had come down to 77 minutes, a reduction of 8.33%.
2. By working closely with the local emergency system and regional network of healthcare providers, the

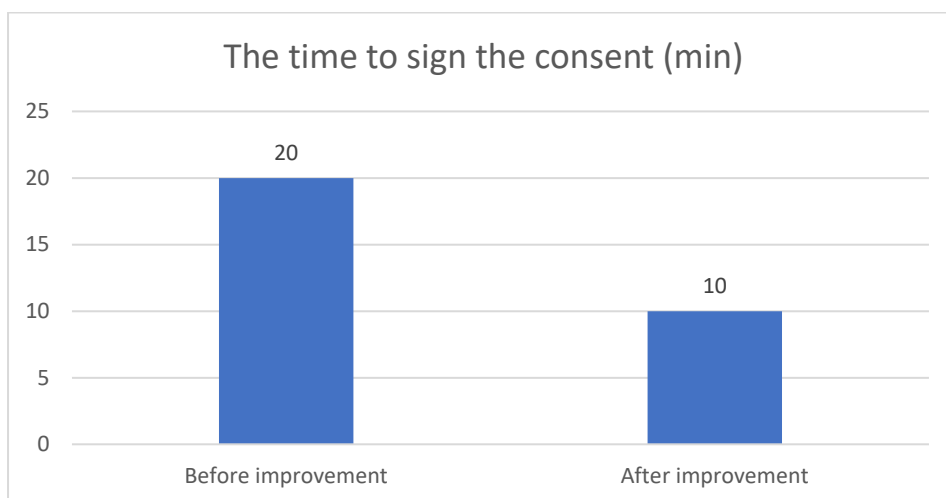
average time of STEMI patients from first arrival to first ECG had been shortened to within 10 minutes.

3. By setting Green Channel to reduce patient transfer time, the activation time of Cardiac Catheterization Room had been reduced from 30 to 20 minutes, a reduction of 33.3%.





4. By improving multi-disciplinary emergency practice, team cooperation and communication with patients in the process of obtaining informed consent, the time taken for patients to sign the consent form had been reduced from 20 to 10 minutes; a reduction of 50%.



5. Patient satisfaction had also improved from 97.5% in 2018, 98.4% in 2019 to 98.5% as at 30/6/2020.

5. Striving for Best Practice

1. From 1/1/2018 to 30/6/2020, we received a total of 8306 chest pain patients, of whom 259 were STEMI patients. The average DTW time of STEMI patients had shortened from 117 to 77 minutes, an improvement of 34.19%.

2. By setting up our Chest Pain Center and by fostering multi-disciplinary and interdisciplinary cooperation, we were able to improve the skills and competencies of our medical staff in managing STEMI patients, and improved our professional image in the community as a caring and high performing hospital.



INNOVATION IN PRACTICE AND PROCESS

We have done the following activities:

1. Foster cooperation with other healthcare providers within our geographical region to manage acute coronary disease patients by:

(A) Establishing an alliance with 8 hospitals and setting up a liaison system to manage ambulance transfer and patient transit between hospitals;

(B) Developing an information-sharing platform for transmitting patient's real-time ECG and medical history to enable cardiologist to give 'remote' support to emergency personnel and provide joint-consultation within 10 minutes;

(C) Displaying highly visible Chest Pain Centre signages within and outside the hospital compound to guide patients to speedily locate the Centre for treatment.

(D) Recording authentic, accurate, objective and timely data on timeline and treatment of STEMI patients and uploading such data in the National online platform for information sharing with other Centres.

2. Formulate mechanisms, process flow and Standard Operating Procedures to optimize timely and appropriate care of STEMI patients by:

(A) Setting up a Green Channel (Appendix II) for this group of patients to directly enter the cardiac interventional suite instead of arriving at A&E;

(B) Treating them before fee charging to obviate delay (Appendix III);

(C) Setting up a "Clock Unified Scheme" to ensure accurate recording of time period for each treatment stage;

(D) Arranging nurses of DSA Department to be on call and activating back up plan (Appendix IV) to ensure timely cardiac interventional procedures can be performed 24/7;

(E) Improving the arterial puncture success rate by immediately trying femoral artery access should difficulty be encountered with radial artery.

3. Enhance knowledge, skills and competency of staff in diagnosing and treating STEMI patients by the following training program:

(1) Training doctors how to make the differential diagnosis of chest pain and how to deal with the chest pain patients in A&E.

(2) Training doctors how to make the STEMI diagnosis from ECG in Pre-hospital emergency.

(3) Enhancing the important of interdisciplinary cooperation.

(4) Training doctor's communication skills, improve the effective preoperative communication: emphasize the importance of PCI.

4. Providing free clinic for the community:

(1) Regularly holding seminar, health talk and Q&A activities in the community, providing the public with relevant knowledge of how to identify the early performance of heart disease and how to do emergency self-help.

(2) Distributing popular science paper-based materials (Appendix V) about heart disease to the community.

(3) Providing heart-disease screening service such as the physical examination in the community.

APPLICABILITY TO OTHER SETTINGS

HKU-SZH has shared its good practice with other hospitals and healthcare professionals. The good practice can be introduced and implemented in other settings hospitals.

REFERENCES

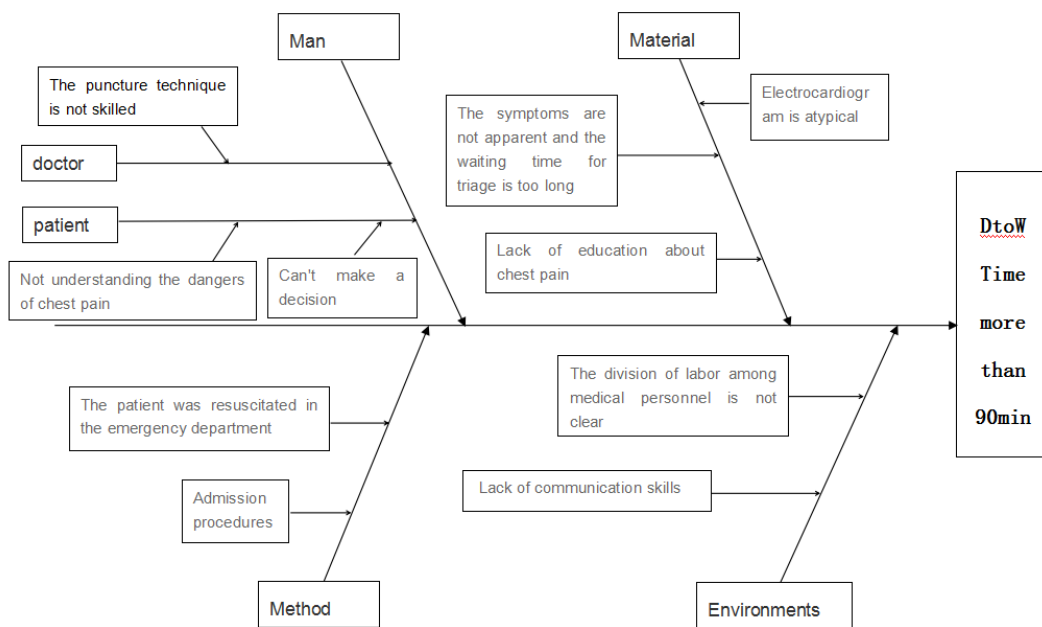
[1] Breukmann F, Hochadel M, Voigtlander T, et al. On versus off-hour patients with acute coronary syndrome and persistent ST-segment elevation in certified German chest pain units[J]. *Eur Heart J Acute Cardiovasc Care*, 2017, 6(1); 3-9

[2] Yancy C W, Jssup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of heart failure; a report of the American College of Cardiology Foundation/American Heart Association Task Force on practice guidelines[J]. *Circulation*, 2013, 128(16); e240-e327



APPENDIX

Appendix I

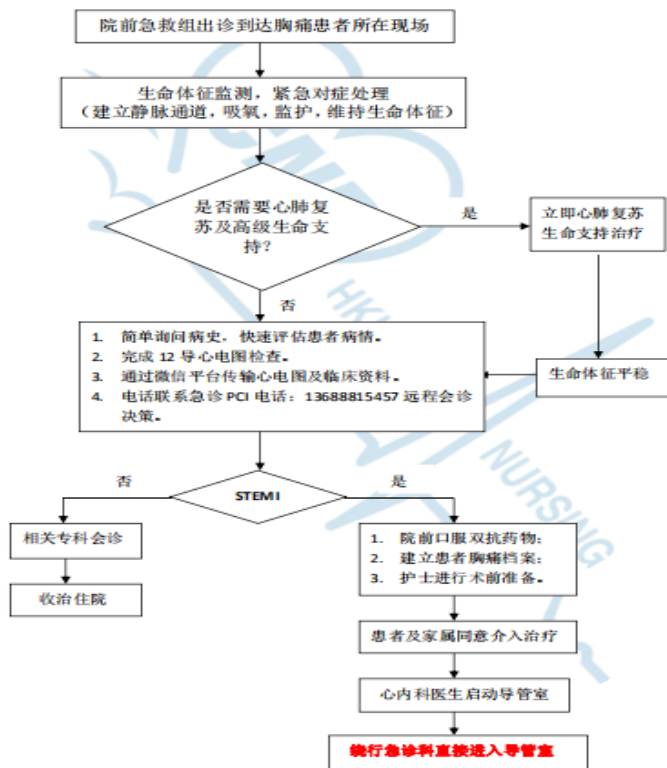


Appendix II

香港大学深圳医院 The University of Hong Kong Shenzhen Hospital	医学影像科	文件编号	ND-MID-IV-053-20180724
		版本	第 1 版
		生效日期	2020.05.20
	急性胸痛患者从院前急救绕行急诊科进入导管室流程	检视日期	2023.05.19
		页码	1 / 2

Setting up a Green Channel that direct access to the cardiac interventional suite instead of arriving at A&E.

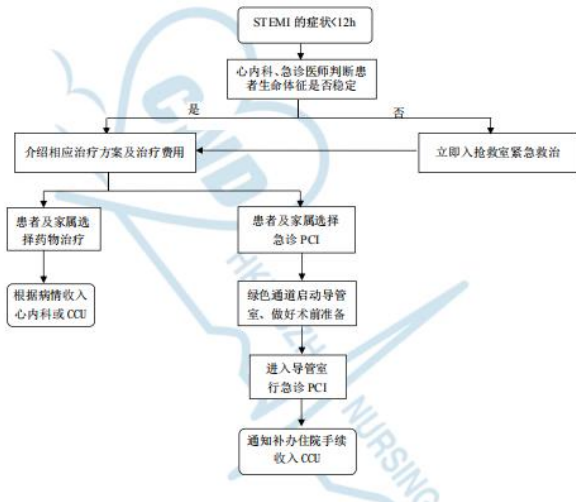
急性胸痛患者从院前急救绕行急诊科进入导管室流程



Appendix III
Treating STEMI patients before fee charging to obviate delay.

 香港大学深圳医院 The University of Hong Kong Shenzhen Hospital	医学影像科	文件编号	NP-QID-PC-059-20180423
	STEMI 先诊疗后收费流程图	版本	第 1 版
		生效日期	2020.05.20
		检视日期	2023.05.19
	页码	1 / 1	

STEMI 先诊疗后收费流程图



Appendix IV
Arranging DSA department nurses to be on call and activating back up plan to ensure timely cardiac interventional procedures can be performed 24/7.

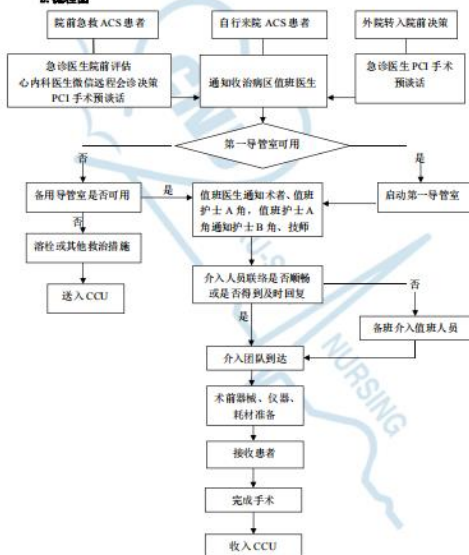
 香港大学深圳医院 The University of Hong Kong Shenzhen Hospital	医学影像科	文件编号	NP-QID-PC-017-20180623
	心导管室激活流程图及启动机制	版本	第 1 版
		生效日期	2020.05.20
		检视日期	2023.05.19
	页码	1 / 2	

心导管室激活流程图及启动机制

1. 概述

心导管室激活流程图及启动机制是针对急诊 PCI 患者从急诊科到完成手术的过程指引。

2. 流程图



Appendix V

Distributing popular science paper-based materials about heart disease to the community.



GLOBAL QUALITY IMPROVEMENT

HIGHLY COMMENDED

Hong Kong University Shenzhen Hospital, China

Clinical Oncology Centre

Advocacy to provide good quality oncology services during the COVID-19 pandemic*A.W.M. Lee, Xu Zhiyuan, Hui Siu Kee Tim and Dong Fule*

AIM

To provide high quality oncology service and a safe environment for patients during the COVID 19 pandemic.

SUMMARY ABSTRACT

The COVID-19 pandemic is a devastating catastrophe to the whole world, China is the first country seriously affected. This review shows that it is possible to stop wide-spread infection in the country and to provide good quality oncology services even during this challenging period, through concerted efforts with well-organized actions at all levels (National/Municipal, Hospital and Department). The key strategies leading to successful impacts are summarized for sharing. In addition to making practice changes to cope with the adverse realities, oncologists should also work together to raise pragmatic suggestions to policy makers and be strong advocates to protect our patients from the detrimental effect of delay or compromised treatment.

Hong Kong University Shenzhen Hospital, China

Department of Nursing, General Medicine ward

Multidisciplinary Team Approach to Reduce the Incident Rate of Fall in Medical Ward*Lan Ping Shi, Yan Zhi Yi, Jian Fen Cao, Pei Shan Li, Chun Hong Liu, Li Qiong Zhou, Shan Shan He and Qiu Li Chen*

AIM

To enhance safer patient care by reduce patient fall and the severity of fall injury through establishing a multidisciplinary team consisting of medical doctors, nurses, pharmacists, physiotherapist and administrative staffs. The team will continuously monitor fall incident, implement quality improvement intervention and evaluate outcomes in inpatient medical wards in order to reduce patient fall and the severity of fall injury.

SUMMARY ABSTRACT

The STEEM program is a continuous quality improvement (CQI) programme for fall prevention, tailored for general medical ward patients as most are elderly and they are especially vulnerable to fall. This programme was initiated by the fall prevention team and well supported by the medical team,

pharmacology department, physiotherapy department and hospital administration department. The programme was implemented from July 2019 to March 2020 and throughout all general medical wards. The former fall prevention practice included a fall risk assessment and general health education for all kinds of patients. The STEEM programme consists of components in Standardization of fall prevention practice (S), Training regarding fall risk identification, modification and elimination for health care workers (T), Education for patient and family members (E), safety Environment and use of Equipment (E) and Medication alerting system(M). Results suggested a significant decreased in fall incident rate from 0.52‰ before CQI to 0.26‰ after CQI. In terms of severity of injury after fall, the incidents of grade 2 injury had 60% reduction, from 0.05‰ to 0.02‰ and grade 3 injury from 0.03‰ to zero cases. The occurrence of fall incidence related to environmental and equipment issues decreased from 30.4% to 17.2% after implementation of the programme. By ward visit and staff interview, it is testified that the CQI programme had comprehensively involved almost all health care staff in the medical department, from preparing the fall prevention information to setting up the safety information corner for patient and carer's education. We can conclude that a long-term mechanism for fall prevention is formed and it forms a good culture of everyone take care of patient fall for safety.

Hong Kong Baptist Hospital, Hong Kong SAR**Nursing Administration Office****Multidisciplinary Fall Prevention Strategies to Reduce Falls in hospital***Li Yuen Man Hilda, To Ka Wing, Cheung Ching Yee**Cindy, Cheung Kim Keung Dennis, Yuen Wing Sze**Jammie, Wong Oi Lan Ellen and Lee Wai Yee Susanna***AIM**

Reduce patient fall with the enhancement of patient safety culture

SUMMARY ABSTRACT

Patient fall is a common organizational risk among hospitals. The risk is mainly due to unfamiliarity with the hospital environment and the change of physical condition after admission. Especially in the elderly group, falls affect mortality and morbidity. As the number of elderly patient admission increased, fall prevention was prioritized in patient safety in our hospital. A range of fall prevention measures was carried out after the establishment of the Fall Prevention Workgroup in 2009.

Each unit has nominated one to two Fall Ambassadors. They are responsible for analysing the fall incidents, sharing the learning points in the workgroup meeting, and bringing the message back to their unit. We also standardized the practice and ward round sheet after obtaining consensus in the meeting. To facilitate Fall Ambassadors' analysis work, a fall incident investigation form was used in 2018, which guided them to evaluate their performance. We adopted the valid assessment tools – Morse Fall Score for Adult (see Appendix 1), Humpty Dumpty Fall Scale for Paediatric (see Appendix 2) – in 2013. Audit on Fall Prevention Assessment was done on a regular basis, and data were shared with frontlines afterwards.

Fall incidents did not just happen in the ward area, as patients were mobilized to other departments for investigation or treatment. Therefore, a standard fall alert sign (see Appendix 3) was created and put on the patient folder of a high risk of falls to enhance communication of fall risk across departments. On top of the introduction of the fall prevention program to both nursing students and newcomers to prepare their participation, a refresher course was conducted to the existing staff periodically.

Patient and patient's family members are also the major stakeholder for fall prevention during hospitalization

and after discharge. A fall prevention brochure would be introduced once the patient is admitted (see Appendix 3). Through the fall investigation, specific groups of patients were identified as high risk of fall in our hospital. Focused fall preventive measurement for specific groups was promoted, such as patients admitted for endoscopy or taking sleeping pills. To encourage patient involvement, an alert board would be placed at the bedside to inform the possible consequence after taking laxative for the bowel preparation before endoscopy (see Appendix 3) or taking sleeping pills (see Appendix 3). Thus, our fall prevention education would be not only given to patients but also involved their family members, and their participation was encouraged in the hospital. Another example could be found in the Paediatric group. We stick an alert bar on the cot to remind the parents to raise the bedrail if they left their baby inside the cot. This measure significantly reduced the baby fall rate in the Paediatric ward and kept at a low level (see Appendix 3).

To build up safety culture, multidisciplinary engagement is essential. Clinical pharmacist, physiotherapist, and risk managers were invited to join the Workgroup in 2015 and 2018, respectively. With their inputs, medication review for primary and secondary fall prevention was started in 2015 (see Appendix 4). The clinical pharmacist alerts the case nurse about their findings from the medication review process. Physiotherapist brought in programs to benefit patients. In 2017, a program of safe usage of walking aid (see Appendix 5) was introduced. By using different colour codes on the walking aid, the nurse could distinguish the patients' independency on using a walking aid. Frontlines could provide suitable assistance immediately on patient rehabilitation stages. In 2019, the Berg Balance Scale Assessment and teaching exercise were promoted to neurological deficit patients. Improvement could also be found in their daily living activities after training. Risk managers made us visualize the preventive measure outcomes with statistics. They act as facilitators to stimulate new ideas generation in the meeting.

Different types of fall prevention devices were on trial in 2018. From data reviewing, we found that the fall alarm pad was effective in preventing the fall incident, particularly to those non-compliant patients. This type of fall incident was dropped significantly. This finding encouraged us to promote the use of a fall alarm pad in other wards. With support from senior management, all wards could equip with the device in 2020. Data collection on its usage and performance would be continued for further analysis. Although the use of restraint was one of the methods to prevent falls, it

should be regarded as a last resort; and the most important is to ensure the appropriateness of application. HKBH collected the monthly statistics on the use of restraint since 2017. The result found it was at a low rate. In 2020, a “use of restraint” audit was done to assess the staff compliance to the essential elements in policy, in terms of appropriateness and monitoring care.

The satisfactory result was shown after years of continuous improvement programs. The fall incident rate was significantly decreased from 0.42 in 2013 to 0.23 in 2019 per 1000 patient days.

Establishing a safety norm in fall prevention should involve multidisciplinary departments. Prevention of patient fall cannot solely rely on a single party. Patients, caregivers, healthcare team have their unique role but complement each other, which like playing a puzzle. The player is expected to put pieces together in a logical way to arrive at the correct solution of the puzzle. When designing fall prevention strategies, each patient would be reviewed case-by-case individually. Through the “Plan-Do-Check-Act” cycle, each healthcare care teammate could contribute their expertise to reduce the risk of patient falls, in the meanwhile, they could cooperate under a well-structured fall prevention program to achieve patient safety.

International Medical Centre, Kingdom of Saudi Arabia

Pharmacy Department

Waiting Time of Out Patient Pharmacy

Ali Saber, Basmah AlQumysh, Jamal Siddiqi and Reham Salem

AIM

To Reduce the Average Waiting Time by 60% (90% from the Total patient < 10 minutes)

SUMMARY ABSTRACT

Observation:

- The average of waiting time in the outpatient pharmacy reached 25 minutes per patient per shift prior to July 2019.
- Long waiting time in the pharmacy makes the patient frustrated, angry, therefore increases the patient complains and Aggravates stress on staff.

Study Current process:

- Giving the patient ticket number for Outpatient and Retail pharmacy if any
- The number called in the LCD

- Pharmacist review the prescription and start to process the order
- Prepare the medication and delivered to the patient with proper counselling

Improvements applied:

- Replace the triage pharmacist with Self-Serving Ticketing machine.
- Software and hardware upgrade
- Centralized printer so invoices will be printed upon the patient request only (environment-friendly change).
- Solving the Insurance approval problems.
- Modify the working hours
- Encourage medication error reporting that affect order processing time, to be followed by pharmacy manager and quality coordinator with the concerned department.
- Staff engagement with daily achievement, performance and process improvement status; illustrated in graphs to Encourage positive competition.
- Create KPI and daily reports.
- Initiate daily Outpatient pharmacy huddle.

Outcome:

The average waiting time decreased by 60% and 90% from the Total patient reach 5 minutes

Royal Bahrain Hospital, Kingdom of Bahrain**Infection Control and Quality****COVID 19 Prevention and control Strategies**

Anal Thankappan, Dr. Tariq Almusawi and Rehana Nazir

AIM

- To prepare the hospital and community to prevent COVID 19 pandemic
- To facilitate the required infrastructural modifications and operational changes required
- To prevent spread of infection within the organization

SUMMARY ABSTRACT

The sudden onset of the current pandemic has put everyone on fear and uncertainty. The questions and dilemma created by the situation is not small and day by day it started to build up and more.

Royal Bahrain Hospital as one of the leading private health care organization which is part of KIMS health group in Bahrain have stepped up and acted for the betterment of the community, customers, and the employees. A committee of core team was formed and activated to plan and develop strategies for research, developing and implementing plans to manage the outbreak with infection control officer heading the team. Following were implemented

- Identification and isolation of suspected cases before entering hospital – process flow (appendix 01) and protocol implemented
- Visual triage and temperature screening at the entrance – checklist implemented to cover risk identification to proper identification and isolation of suspected cases
- Screening ID tags are implemented to identify who all are screened and who is suspected – Green ID band for suspected and Purple band for regular patients
- Screening identification stickers for staff also implemented – helped to given confidence for the patients, visitors, and employee
- Visitors policy revised – visiting time revised 11 am to 12 noon and 6 pm to 7 pm
- Face Masks are made mandatory before entering inside the hospital
- Patient Room Decoration items from outside stopped
- Hand sanitizers made available in all the common areas and at the entrance

- Made Negative pressure room in Emergency Department
- Social distancing stickers placed on floors and chairs in waiting area
- Guest relations team and safety team ensured that social distancing is followed in the hospital
- Protection glass barriers kept on the reception counters for staff protection
- Face mask policy implemented
- COVID screening was made mandatory for all suspected ED and all IP and pre-op cases including for accompanying person in OT and labor room
- PPE is made available and usage is reinforced. Compliance is being monitored in different level by supervisors and infection control team
- Random COVID screening for staff. Positive staff are isolated and treated and contacts are quarantined as per Bahrain MOH protocol
- Fumigation restarted for high risk areas including transport vehicles
- Policy and process flows for COVID 19 management is implemented and reviewed and updated based on NHRA and MOH Bahrain
- Contract tracing of positive patients and staff

Prevention strategies are implemented and trained the staff to follow

- Frequently wash hands with soap and water for at least 20 seconds. When soap and running water are unavailable, use an alcohol-based hand rub with at least 60% alcohol. Always wash hands that are visibly soiled.
- Avoid touching eyes, nose, or mouth with unwashed hands.
- Practice good respiratory etiquette, including covering coughs and sneezes.
- Avoid close contact with people who are sick.
- Stay home if sick.
- Recognize personal risk factors. According to U.S. Centers for Disease Control and Prevention (CDC), certain people, including older adults and those with underlying conditions such as heart or lung disease or diabetes, are at higher risk for developing more serious complications from COVID-19.

Environmental Cleaning and Disinfection

Daily/periodic cleaning

- Consider designating specific, well-trained housekeeping personnel for cleaning and disinfecting of nCoV patient rooms/units.
- Trained staff are designated for a week for cleaning and disinfecting the isolation room
- Log maintained on the staff designated for cleaning isolation room



- d. The supervisor should make sure the staff designated are well trained on the cleaning protocol
 - e. Nurses / health care assistants are primary responsible to ensure medical equipment cleaning
 - f. Nursing supervisor and HK supervisor will monitor and ensure the cleanliness is maintained
 - g. Checklists are maintained by HK supervisor to ensure accountability for cleaning responsibilities.
 - h. Housekeeping personnel wear appropriate PPE as above.
 - i. Housekeeping staff are trained by the infection control team about nCoV, in proper procedures for PPE use, including removal of PPE, and the importance of hand hygiene.
 - j. Cleaning supplies are outside the isolation room
 - k. Areas around the patient are kept free of unnecessary supplies and equipment to facilitate daily cleaning.
 - l. Hospital -approved disinfectants are used. Follow manufacturer's recommendations for use-dilution (i.e., concentration), contact time, and care in handling.
 - m. Clorox is used for cleaning and disinfection of the isolation room. Dilution 100 ml in 1 litre of water.
 - n. Clean and disinfect the isolation room daily and more often when visible soiling/contamination occur.
 - o. Special attention on frequently touched surfaces (e.g., bedrails, bedside and over-bed tables, TV control, call button, telephone, lavatory surfaces including safety/pull-up bars, door knobs, commodes, ventilator and monitor surfaces) in addition to floors and other horizontal surfaces. Clorox with same dilution to be used
 - p. Wipe external surfaces of portable equipment for performing x-rays and other procedures in the patient's room with 'Universal disinfecting wipes' after using for a suspected patient
 - q. After an aerosol-generating procedure (e.g., intubation), clean and disinfect horizontal surfaces around the patient. Clean and disinfect as soon as possible after the procedure.
 - r. Clean and disinfect spills of blood and body fluids for spill management
 - s. Linen shall be considered as highly infected and follow the policy for handling infectious linen. Hot water soluble bags to be used
 - t. Waste from the isolation room will be considered as infected and yellow garbage bag will be used.
- Terminal Cleaning:
- a. Standard procedures are followed for terminal cleaning of an isolation room after patient transfer or discharge
 - b. Diluted Clorox solution is sprayed in the isolation room and keep it closed for 10 minutes before entering to the room for cleaning
 - c. All surfaces are cleaned and disinfected that is in contact with the patient or may have become contaminated during patient care including items such as blood pressure cuffs, pulse oximeters, stethoscopes, etc. using diluted Clorox solution
 - d. Mattresses and headboards are wiped with diluted clorox solution.
 - e. Privacy curtains are removed, placed in hot water soluble bag in the room and then transported to the dirty linen room.
 - f. Walls, and other surfaces are wiped with diluted Clorox solution
 - g. Fogging is done for 15 minutes after the deep cleaning procedure
 - h. The room is closed down for 45 minutes before assigning for new patient.
 - i. The designated lift for COVID suspects are cleaned and disinfected with diluted Clorox solution



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