GUEST EDITORIAL

ENABLING FRONTLINE HEALTH CARE PROFESSIONALS TO REINVENT PRACTICE IMPROVEMENT USING VIDEO FEEDBACK

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Introduction
Frontline health care professionals, patients and relatives are increasingly recognised to be a critical asset to realising health care improvement. We now also acknowledge that understanding of ‘service context’ is critical to enhancing the chance of uptake of policy reform and new guidelines. Putting these two insights together is producing some powerful examples of targeted, site-appropriate and sustainable change.

The Agency for Clinical Innovation is at the vanguard of involving volunteer frontline clinicians and consumers in its practice improvement initiatives and committees.
These clinicians' and consumers' involvement means that people working or receiving care at the frontline now have a say in how to deploy policies and guidelines as well as in amending and even in developing them. The ACI Redesign School is a case in point. Nurturing local enthusiasm to engage in improvements that make sense to clinicians and patients at the frontline is a critical step forward towards real, consumer-focused reform.

**The challenge of complexity**

When defining the focus of a redesign project, we understandably choose challenges that are apparent to us from outcomes data, staff and patient feedback, resource issues, and so forth. Focusing redesign efforts in this way is absolutely critical, and the Redesign School shows evidence of already having produced important results.

There are also challenges that are incredibly complex because they straddle units, professions, shifts and whole services. Take a hospital-acquired condition like an infection. Yes there are policies in place advising staff what to do and how. And there is plenty of research showing that consistent hand hygiene is critical to reducing cross-infection. But when you ask frontline staff about in-hospital acquired infection they often seem resigned: "what we do makes no difference". What makes this so complex is that staff can't identify the source of the risk, colleagues often have their own interpretations about what policies mean, and again others feel the problem does not apply to them.

The 'WHO 5 moments' policy is clear on infection control and hand hygiene. But in it, care is shown as a linear, uninterrupted trajectory going in and then out of the patient’s space, with clear hand hygiene points. Now imagine video-ing clinicians’ in action with their patients, and then reviewing the footage. What you see does not resemble a nice, linear trajectory.

Your footage reveals what actually goes on: multiple people entering and leaving the patient’s bed space, sometimes several at once. Each of these people (staff, relatives) comes into contact with the patient and/or their environment in different ways. The patient him or herself may move through and out of the bed space, even when they have been identified as (likely) infectious. Then there are all sorts of objects – trolleys, technical equipment, family gifts - that move across infected – non-infected boundaries. This is complexity in action.

**Reinventing improvement theory**

Improving practice amidst complexity is difficult, but not impossible. It requires more than rules, however comprehensive and detailed. Now at this point we need to invoke a bit of theory.

'Pragmatism' is a theory according to which actors are limited when it comes to being aware of and changing habituated behaviour. John Dewey, one of the most prominent pragmatist philosophers of the 20th century, stated this idea as follows: Our actions do not issue from conscious thoughts or intentions motivating their execution. On the contrary, our actions emerge from habituations which are buttressed by taken-for-granted context conditions. Here, conscious thought and free will hardly play a part.

> Conditions ... can no more be dismissed by a direct effort of will than the conditions which create drought can be dispelled by whistling for wind. It is as reasonable to expect a fire to go out when it is ordered to stop burning ...

Dewey's theory turns practice improvement science on its head: there is no point appealing to people's conscious thoughts and conscious behaviour, because they are not what drives their actions. Real improvement needs to start somewhere else altogether.

**Reinventing improvement methodology**

One way of gaining entry into the dense collusion between our habituations and context conditions is by video-ing what we do and scrutinising the resulting footage. This is what high-level sports people do to snare ineffective moves. In our experience, when clinicians see themselves on screen they often say, 'this is amazing, I've been in this job for decades, and I have never seen myself do what I see myself doing on the screen!' The next thing they’ll say is, 'What I’m seeing does
not make sense. That is not the clinician (or the team) I want to be.' Then, they're usually off redesigning their care pathway or their clinical space.

We at the Centre for Health Communication at UTS have practised video-ethnography now for more than a decade. We've worked with spinal care, ICU, emergency, renal, surgery, and a range of other specialties. With local and overseas colleagues, we have brought our achievements together in a book. We explain how video-feedback enables people to intervene directly in how they are (their habituations) and in how and where they act together (context conditions). By observing themselves at work, they witness the enormous effort they put into their work, they become aware of any remaining limits in their ways of working, and they become enthusiastic about being enabled to contribute to meaningful improvement.

**Conclusion**

The founder of care quality research, Avedis Donabedian, always maintained that objective data about systems was not enough to achieve improvement. Without professionals' enthusiasm no amount of data would generate significant reform. Video feedback inspires professionals across the globe because it puts them and their patients in charge of redesigning everyday practice. Video ensures their voices are heard when it comes to improving local outcomes, working out how to meet targets, and reforming practice in line with patients' wishes and emerging policies.

**References**


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Dr Nigel Lyons
**COMMENT BY THE CHIEF EXECUTIVE**

Often it is the seemingly insurmountable problems that drive us to innovate. The challenges we face which lead us to new ways of delivering care.

With the impact of technology, an ageing population, rising levels of chronic disease and increasing consumer demand, healthcare professionals and managers are
working harder than ever before to provide the best quality care to their patients.

These efforts and the people behind ideas driving improvements across the health system were acknowledged at the recent Innovation Symposium. My congratulations to everyone who were finalists or received an award, including ACI Board Member Gabriel Shannon, recognised for his significant leadership and collaboration on local solutions in Orange.

Opportunities like these to celebrate the wins, share learnings and reflect on what’s needed to foster innovation are important. The clear direction at the Symposium, to provide the space and resources to explore new ways of providing care, will pay dividends across the health system. It will impact on how we all innovate, and how we react to the next big idea.

But how do we drive change across our complex health system with its different hierarchies of need, and ever increasing demand? Where will resources to support good ideas come from? And which ideas should be given a run?

We’ve been wrestling with this over the past year at ACI and know that getting it right will not be easy.

One thing we are sure of is that a careful and current assessment of what we are doing must be part of any strategy to innovate, as it has the potential to free up resources that can be applied to foster new ideas.

We must also recognise that not all ideas are good nor are all innovations successful. Our ideas must be evidence-based and tested, and when deciding between ideas, reasoned priority setting must involve consumers, clinicians and managers. We must also seek consensus early on what the benefits are, who will receive them and in which circumstances.

As a public agency, we are more conscious than most that the resources we are allocated must be used to the greatest benefit of the NSW community. This is why we are introducing a rational, explicit and transparent priority setting framework to guide our work.

On behalf of the ACI I would like to thank ACI’s Clinical Lead Tracey Tay and everyone involved for lending their expertise, time and commitment to develop and test this Framework, which provides a practical approach to prioritise initiatives identified by ACI Clinical Networks, Taskforces and Institutes.

Innovation is everyone’s business – and the key to the future success of the health system. We all need to see insoluble problems as great opportunities.

*Making Choices: A framework for prioritisation within ACI Clinical Networks, Taskforces and Institutes* is available on the ACI website.
Framework for Integrated Care for Older People with Complex Health Needs

The ACI is leading the development of a Framework for Integrated Care for Older People with Complex Health Needs on behalf of the NSW Ministry of Health.

The Framework aims to support providers to ensure that older people, their carers and families receive appropriate, evidence-based quality healthcare in a timely, equitable and co-ordinated manner and delivered safely as close to home as is possible.

A diagnostic report has now been completed and is available on the ACI website. The report describes current best practice models of care and highlights consistent themes, enablers and barriers to integrated care.

The diagnostic was a snapshot based on consultation with key stakeholders and visits to ten sites across NSW. Further consultations will be conducted with older people’s mental health, rehabilitation and palliative care services during the development phase of the Framework.

Key findings from the report include:

1. **Older person centred philosophy of care**: where there was a visible/published philosophy of care, there was a shared view on what care should look like.

2. **Strategic purpose to the management of older people with complex health needs**: where there was executive level sponsorship and understanding of strategic imperative to treat older persons as a specific group, there were specific strategies to improve care and system efficiencies.

3. **Access to services for older people**: unnecessary presentations to emergency resulted from inabilities to access timely and appropriate care and/or support.

4. **Relationships**: between and across organisations, models of care and programs relied largely on informal relationships such as personal relationships, co-location and frequency of contact.

5. **Communication**: older person their carers and families want to have their disease or diagnosis clearly explained, understand their care plan, and know who to contact, what services are available, how to access them and associated costs.

6. **People and staffing**: resourcing and capacity were identified as a limitation in both metropolitan and rural sites. Common themes for successful staffing models include collaborative multidisciplinary teams, interdisciplinary links between specialities, regular communication, colocation of staff and alternative staffing arrangements.

7. **Funding arrangements**: there are multiple funding sources that are duplicative, inconsistently distributed and time limited.

8. **Infrastructure**: there was a lack of consideration for the needs of older people in infrastructure planning. Sites that were involved in infrastructure planning developed environments that were conducive to person centred care.

9. **Technology**: there was a lack of interface between Information and communication technologies which impacted on the continuity of care and create administrative burdens.
10. **Governance**: no one organisation, team or service has the whole picture of the health needs of older people. Some sites visited had successfully created aged health governance arrangements extending across local health providers including residential aged care facilities, local non-government organisations, Medicare Locals and General Practitioners.

11. **Continuity of care**: strong relationships, both clinical and non-clinical were pivotal to continuity of care outside the hospital.

Thank you to everyone who participated in the site visits and consultations. For more information, contact the Network Manager.

**Framework Workshop**

The ACI hosted a two day solution design workshop for the *Framework for Integrated Care for Older People with Complex Health Needs* with PricewaterhouseCoopers on the 17 and 18 September 2013. The workshop was attended by more 50 participants from Local Health Districts, Medicare Locals, Ambulance Service of NSW, Aged Care and Community Care services as well as carer representatives. The workshop updated participants on project findings to date and informed the design of individual components of the Framework, which will undergo consultation before being finalised in late 2013. For more information, contact the Network Manager.

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**Environmental Cleaning**

The ACI Blood and Marrow Transplant (BMT) Network is currently undertaking a BMT Environmental Cleaning (BMTEC) Project to support the updated Environmental Cleaning Policy and assist Local Health Districts to meet new national accreditation standards. The project also addresses recent recommendations from the Health Care Complaints Commission.

The specific aims of the BMTEC Project include:

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**Clinical Network Report**

**BLOOD AND MARROW TRANSPLANT**

**Co-Chairs**: Chris Arthur and Louisa Brown

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Establishing a minimum level of environmental cleanliness across all NSW hospitals

Determining the methods by which units are cleaned (frequency, process), resourcing, training and education of environmental service personnel and clinical governance

Piloting and validating the Clinical Excellence Commission NSW audit tool

Informing quality improvements in environmental cleaning standards.

Malignant Haematology and other BMT patients are at high risk of many common hospital acquired infections and respiratory viruses, all which have the potential to result in high levels of antibiotic use, instrumentation and often long and repeated hospital stays.

The BMTEC Project is currently being implemented in all Local Health Districts across NSW. The ACI team, led by Nicky Gilroy and Kerry Newlin, has now accompanied the external reviewer from Infection Prevention Australia across thirteen sites. The remaining two site visits are scheduled for early October 2013 with further rounds in early 2014. The data collected during Round one site visits to date has identified a number of areas for immediate action and performance improvement. BMT units will be provided with an interim report detailing the findings of the first round audit along with recommendations for strategy implementation prior to the second round two in early 2014.

Quality Management Service

The Liverpool Hospital BMT Service was assessed by the National Association of Testing Authorities (NATA) in July 2013. The service, including apheresis collection and BMT processing, was found to be operating at a high standard overall, with its current NATA accreditation continued. The processing laboratory extended its scope of accreditation to include chimerism analysis of allogeneic transplants. This is a unique achievement as this analysis is traditionally performed by molecular genetics departments. The laboratory becomes the first processing facility in the ACI BMT Network to perform this analysis in-house. Congratulations to the Liverpool team.

The Cord and Marrow Transplant Program at the Kids Cancer Centre, Sydney Children's Hospital, in conjunction with the Prince of Wales Processing Laboratory, was assessed by the internal accreditation body Foundation for the Accreditation of Cellular Therapy (FACT) during September. This service continues to operate at a comprehensive level and was recommended for ongoing accreditation. One of notable changes to accreditation requirements is an implementation plan for a system that enables the use of the internationally recognised labelling system ISBT128. The BMT Network is currently reviewing options and will be present a draft implantation plan to all affected BMT services in the coming months.

BMT Events

The BMT Clinicians Meeting was held on 5 September 2013 at the Novotel Sydney Olympic Park. The meeting brought together likeminded clinicians and scientists to discuss the work and activity of the ACI BMT Network and to inform the ongoing work plan. The working dinner saw a key note presentation from Ken Bradstock to more than 48 BMT Network members.

The BMT Network hosted the 10th Annual Scientific Symposium on 6 September 2013 at the Novotel Sydney.
Olympic Park. The event saw more than 100 BMT clinicians attend and included presentations from Mark Hertzberg, Kenneth Micklethwaite, David Ritchie (Royal Melbourne Hospital), Paul Chiappini (Cell and Tissue Therapies WA) and Susan Dunn (NSW Ministry of Health). The presentations were captured on the day and will be made available to Network members via the new BMT web portal. For more information please contact the Network Manager.

The BMT Network Paediatric Study Series was also hosted at the Northern Sydney Education and Conference Centre, Macquarie Public Hospital throughout September. The three day course is for registered nurses working in paediatric BMT units or those who work with pre and post-transplant patients (i.e. referral centres). It is designed to enhance the knowledge of those who work in this highly specialised and exciting field. The Network would like to thank Lucy Maurice and Kay Montgomery for their work in organising the event, the presenters who participated in the series.

Changing of the Guard

Congratulations to John Vandervord, who has been appointed as the new Co-Chair of the ACI Burn Injury Network.

John is the Director of the Royal North Shore Hospital Severe Burn Unit and Head of the Division of Surgery and Anaesthetics at Royal North Shore and Ryde Hospitals. He is also a Visiting Medical Officer for Burns Plastics and Reconstructive surgery at the Children’s Hospital at Westmead. John has worked for over 30 years in the NSW health system as a plastic surgeon, and this appointment will mark his second term as Co-Chair of the Network.

John steps in to fill the spot left by Peter Maitz, who has stepped down as Co-Chair following three years leading the Network in the position. The Network would like to extend our sincere thanks to Peter for his time and contribution to this role. Peter will remain on the Executive Committee of the Network in his capacity as Director of the Severe Burn Unit at Concord Repatriation General Hospital.

Network Manager

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New Co-Chair

The Cardiac Network would like to warmly welcome Glenn Paull, Clinical Nurse Consultant in Cardiology from St George Hospital, who has been elected as Co-Chair. Glenn will replace Trish Davidson, who resigned as Co-Chair in August 2013. Glenn's clinical interests include standardising clinical practice, health literacy, heart failure management, implantable defibrillators and end-of-life care. The Network looks forward to working with Glenn.

State Cardiac Reperfusion Strategy

A cardiac reperfusion training workshop for Information Technology, biomedical staff and Clinical Coordinators was held during September 2013. Attendees received information on the State Cardiac Reperfusion Strategy (SCRS) and were guided through the installation, management and troubleshooting processes for the Lifenet system which is used to transmit ECGs as part of the strategy. Feedback from the event was positive and participants appreciated the opportunity to learn from sites that had already implemented the strategy.

A series of monthly teleconferences with the Executive and Implementation Leads for the reperfusion strategy in each Local Health District (LHD) has now commenced. On Monday, 16 September 2013, Murrumbidgee LHD implemented the Clinical Support Model (CSM) at ten sites. This model allows small hospitals to transmit ECGs to the local Reading Service for expert interpretation and patient management advice. Nurse Administered Thrombolysis (NAT) also commenced at Illawarra Shoalhaven LHD on Monday, 9 September and this model will be used to provide a reperfusion strategy for hospitals without 24/7 onsite medical cover.

Nurses Education Program

The next session of the Nurses Education Program is scheduled for 2.30pm on Wednesday, 23 October. Mick Napoli, Exercise Physiologist from the Sutherland Heart and Lung Team will present on Exercise Prescription for Heart Failure. For details on how to link into the program, please contact the Network Manager.
Thank you to everyone who contributed to the online feedback surveys, interviews, focus groups and consumer forum hosted by the Agency for Clinical Innovation (ACI) between March and May 2013. A full report detailing the feedback we received from consumers and staff can now be accessed on the ACI website. The report highlights the value ACI places on consumer involvement, and provides clear direction for improvements.

View the report: Consumer Engagement in the Agency for Clinical Innovation (ACI): Key stakeholder perspectives.

The ACI will host a workshop in early 2014 to support development of a Framework, tools and resources to support and strengthen consumer involvement. Consumers and other key stakeholders will be invited to provide input and feedback throughout the development process. If you have any questions, please contact a member of the ACI Engagement, Executive Support and Communications Team.

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Nurse Delegated Emergency Care Project

Congratulations to the seven successful sites that will have the Nurse Delegated Emergency Care Project model implemented in Round one.

The successful sites are:

- Bellingen Hospital, Mid North Coast Local Health District (LHD)
- Coolah Hospital, Western NSW LHD
- Cooma Hospital, Southern NSW LHD
- Milton Ulladulla Hospital, Illawarra Shoalhaven LHD
- Nimbin Hospital, Northern NSW LHD
- Pambula Hospital, Southern NSW LHD
- Wilcannia Hospital, Far West LHD

The Nurse Management Guidelines and Medication Standing Orders have been endorsed and are now also available on the Nurse Delegated Emergency Care page on the Emergency Care Institute (ECI) website.

Patient Factsheets

The ECI has now made more than 20 patient factsheets available in a range of major alternate languages, including:

- Arabic
- Chinese Simplified
- Chinese Traditional
- Greek
- Korean
- Vietnamese

The translated factsheets can be accessed on the ECI website.

New ECI Research Co-Chair

Congratulations to Anna Holdgate, who has been appointed as the new ECI Research Advisory Committee Co-Chair. Anne replaces Richard Paoloni who resigned from this position in July 2013. The ECI would like to thank Richard for his contributions to the Network during his time as Co-Chair.

Annual Emergency Care Symposium

A provisional program and registrations for the ECI’s annual Emergency Care Symposium are now open.
Adult Subcutaneous Insulin Prescribing Chart

The NSW Subcutaneous Insulin Prescribing Chart has been now approved by the ACI Endocrine Network following endorsement by Medication Safety Expert Advisory Committee and the State forms Committee.

The Network will support Local Health Districts to implement the Chart.

The ACI Endocrine Network hosted an implementation workshop on 8 October 2013. Representatives from each LHD attended the workshop. They will act as implementation leads across all sites in their respective regions. The Network has developed a comprehensive resources package that is available to LHDs on the ACI website. Resources include:

- PDF version of the Chart
- FAQ sheet
- User Guide
- One page ‘how to’ guide
- User video presentation
- Presentations from the workshop
- Audit tool for each LHD

It is anticipated that each LHD will have the knowledge and skills to implement the subcutaneous insulin prescribing chart. In order to support this process, the Chart is available for LHDs to order hard copies directly via Fuji Xerox.

Standards for High Risk Foot Services

The Standards for High Risk Foot Services in NSW document will be released shortly. The Standards include recommendations for LHDs to:
- Undertake a gap analysis of existing services to identify current access to foot care for people with diabetic foot complications
- Identify variation in service delivery and outcomes
- Align existing services with the standards for High Risk Foot Services
- Explore local capacity to use Telehealth as one of the mechanisms to deliver equity of access to specialist services for those living in rural, remote and isolated communities across NSW

A supporting survey tool has been developed and been piloted in four LHDs. Once endorsed by the Endocrine Executive the tool will be made available to accompany the Standards for High Risk Foot services in NSW. For more information, contact the Network Manager.

**Welcome Back Rebecca, Thank You Danielle**

The ACI Endocrine Network is delighted to welcome Rebecca Donovan back from maternity leave. The Network and Rebecca would also like to extend sincere thanks to Danielle Kerrigan, who was A/Network Manager in Rebecca's absence. Danielle successfully led the progression of many key Network priorities during her time as A/Manager, and will be staying on with the ACI in another capacity.

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**Clinical Network Report**

**‘GRASS ROOTS’ RURAL HEALTH**

One of the key roles of the ACI Rural Health Network is to develop mechanisms which identify, showcase and share innovative rural models of care, to unearth pockets of excellence, share ‘lessons learned’ and reduce duplication across NSW.

With the Australian Resource Centre for Healthcare Innovations (ARCHI) transitioning to the ACI in 2013, the Network decided to undertake an analysis of current Models of Care which have the potential for broader rural implementation and to populate and promote the ARCHI Innovation register as a central place where Local Health Districts (LHDs) can go to access the models.

The recent LHD Quality and Innovation Awards provided an excellent opportunity for the Network to identify new models of care to be added. A total of 20 projects from the seven rural LHDs were identified and are now being uploaded onto the ARCHI register.

A few examples of projects identified to have potential for broader implementation are:

- **Aged Care Access Hub** (Western NSW LHD) – Access to aged care services is co-ordinated through a central hub (Home and Community Care, Non-Government Organisations, LHD, General Practitioners, Package Providers). A

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standardised referral process via a web-based intake system is used to navigate through the maze of services available. Outcomes include decreased clinical variation, increased equity of access and appropriate and timely referrals.
Contact: Debra Tooley, WNSWLHD

- **Up and at ‘em** – early mobilisation in elective orthopaedics in the rural (Bathurst, Western NSW LHD) - Increasing demand and waiting lists for joint replacement and inconsistent models of anaesthetic and post-operative analgesia which limited functionality were resulting in increased length of stay and secondary pressure areas. Early mobilisation (on the day of surgery) and decreasing the use of epidural patient controlled analgesia or peripheral nerve blocks resulted in patients being independently mobile two days earlier and a 42% decrease in acute ward bed days.
Contacts: Andrew Muldoon and Catherine Poschich, WNSWLHD

- **Intangible story telling project for Family and Carers of mental health patients** (Far West LHD) - Uses real stories and creativity to challenge views, workplace culture and community stigma to advocate for and highlight the journeys and needs of carers in the Far West. The use of carers’ stories and showcasing additional issues for carers in a small community such as isolation, lack of service choices, distance and lack of privacy has led to development of resources which have been screened across three LHDs. Resources include a DVD, an education booklet in two voices – one for the health workforce and another for carers/families, and a book: *Intangible* – *Insight and Inspiration*.
Contact: Tanya Clifton FWLHD

- **Reducing non-attendance for Clinic Appointments by SMS Reminder** (Far West LHD) – An electronic appointment management system was introduced at Broken Hill to reduce the high number of patients who "did not attend" clinic appointments. There are 24 clinics in the Broken Hill Hospital iPM patient system with an average of 1500 appointments each month. At the beginning of 2012 there was an average of 190 Did Not Attend’s (DNA) per month. When clinic reception staff enter the patient appointment into iPM a reminder SMS is automatically generated. Work has now commenced to test SMS text message to landline voice message processes.
Contact: Peter McDonald FWLHD

- **Ballina Renal Unit, Advance Care Directive Package** (Northern NSW LHD) – A review of patient records in 2009 revealed that 0% patients had an Advanced Care Directive (ACD) and some patients who did not want advance life support were at risk of extensive interventions. An ACD Package is now included as regular process and the ACD is uploaded into eMR system.
Contacts: Arthur Larmer and Terri Battese, NNSW LHD

- Moree High Risk Maternity Services Clinic (Hunter New England LHD) – Visiting antenatal team from John Hunter Hospital servicing women deemed ‘high risk’ from Collarenebri, Narrabri and Moree save more than 306 days away from home and 90,000km in patient travel.
Contact: Bronwyn Cosh, HNELHD

Nursing the Patient with Intellectual Disability

The Intellectual Disability Network Workforce and Capacity Subcommittee recently approached the Australian College of Nursing about running a pilot course in Nursing the patient with Intellectual Disability.

The College is now working with the Network to evaluate the process of course development and outcomes and consider what future formats and locations might work for ongoing education in this field.

A pilot course was run over two days and attracted more than 22 registered and enrolled nurses from across the state. Participants learned about the Ombudsman’s findings, the patient journey through the hospital system, the role of Medicare Locals and Health Care Assessments, and the challenges of diagnostic overshadowing.

Feedback from the course was positive, with one participant commenting:

"Thanks for one of the most relevant informative course I have been to in ages. ... The speakers were fantastic and the group of nurses were great. It was wonderful to discuss and exchange experiences."

The Intellectual Disability Network will continue to work with the College to finalise a course format and schedule. For more information, contact the Network Manager.

Visiting International Speaker: Gloria Krahn

The Access and Equity Subcommittee recently invited Gloria Krahn, Director, Division of Human Development and Disability, National Centre on Birth Defects and Developmental Disabilities, USA was invited by to address its members in a symposium.

Gloria presented on the Cascade of Disparities for people with intellectual disability, which addressed the high rates of adverse health conditions, the importance of health education and the inclusion of people with intellectual disability in public health campaigns.

Strategies for the increased inclusion of people with intellectual disability and their carers in mainstream health services were also discussed during the symposium, with the three multidisciplinary pilot clinics which form part of the Network speaking of their role in preventative health and consumer engagement.
Pictured: Jacqui Small, Les White, Gloria Krahn and David Dossetor. Photo: T Szanto
Intensive Care Best Practice Project – The IC-Man Project

Friday, 13 September 2013 saw the culmination of 18 months of hard work for more than 120 participants with an event to introduce the individual components of the Intensive Care Best Practice Manual.

The event was attended by key people including Susan Pearce, NSW Chief Nursing and Midwifery Officer, Dr Nigel Lyons, Chief Executive, Agency for Clinical Innovation, Directors of Nursing from the Local Health Districts and representatives from many of the Intensive Care and High Dependency Units across NSW.

Pictured: Back row - Phil Marshall (Nurse Educator Sutherland ICU), Mary Dunford (St George Respiratory CNC), Susan Pearce, Janet Masters (Project Officer), Kim Oleson (LDON SESLHD), Lawrence Keating, (CNS St George ICU)
Front row - Wendy Chaseling (St George ICU Physiotherapist), Dee Power (Prince of Wales ICU Clinical NUM), Kaye Rolls (Project Manager ACI-ICCMU), Suzanne Schacht (District PACE Manager & Program Coordinator St George ICU). Photo: Di Kowal

The IC-Man Project has led to the collaboration of many nursing, allied health and medical clinicians in NSW and has resulted in the development of a number of evidence based clinical practice guidelines that are relevant to the local clinical needs.
The guidelines will be made available for download from IC-WIKI along with the education and implementation tools that project participants have been developing.

The following guidelines were updated or developed:

**Updated**
- Suction of an artificial airway
- Post insertion care of the Central Venous Access Device
- Eye Care
- Oral Care (in progress)
- Arterial Line care (in progress)
- Stabilisation of endotracheal tube (in progress)

**Developed**
- Non-Invasive Ventilation
- Measurement of Temperature in the Critically Ill patient
- Pressure Injury Prevention
- Physical Activity and Movement

For more information, contact the Network Manager.
Tracheostomy Care Guidelines

Following the completion of the Tracheostomy Care Guidelines, a series of Tracheostomy Care Implementation Workshops are planned to facilitate the implementation of this guideline.

Members of the ACI Tracheostomy team including Kaye Rolls, Melissa Tinsley and Cecily Barrack will co-present the workshops in conjunction with local clinical leads.

The aim of each workshop is to:

- Provide local clinicians and managers with an overview of how team based tracheostomy care can be organised at the facility level
- Support facilities to develop an approach to team based care that is appropriate to their case mix
- Develop a community of practice to facilitate knowledge and information sharing at the local level

Register for the workshops.

For more information contact a member of the ICCMU team.

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Clinical Network Report

MUSCULOSKELETAL

Focus on Osteoporosis

Implementation of the Osteoporotic Refracture Prevention Model of Care

Did you know that the Musculoskeletal Network and the ACI Health Economics and Analysis Team, with help from Murrumbidgee Local Health District (LHD) and Medicare Local, Sydney and Hunter New England LHDs, have been able to show that if we systematically implement the Model of Care for Osteoporotic Refracture Prevention across NSW we would:

- Prevent around 242,000 fractures in people who have had a minimal trauma fracture previously – why didn't we identify and treat osteoporosis in these
patients on the first occasion in the very least?

- Avoid the 150,000 re-admissions within 28 days that are directly related to the fracture?
- Realise around $238m notional savings – let alone improve the quality of life of these people who have osteoporosis and re fracture time and time again?

Many health services across NSW are now working to implement the Model of Care in their localities. The Model provides a framework for treatment and self-management initiatives, and is designed to be implemented in community settings with collaborations such as those between LHDs, Medicare Locals, residential aged care facilities and councils and in outpatient settings such as ambulatory care and fracture clinics.

A necessary element of the Model of Care is a Fracture Liaison Coordinator (FLC). International evidence suggests that a FLC is the only way to overcome the present lack of identification of these patients at all levels of the health community\(^1\). Fractures are treated but the underlying cause is often forgotten.


NSW Osteoporotic Refracture Prevention in Berlin

Members of the Musculoskeletal Network were recently able to share the successes and lessons learnt from the Network with an international audience. The outcomes of the Network’s formative evaluation concerning osteoporotic refracture prevention were presented at the second global congress hosted by the Global Fragility Fracture Network in Berlin. The ACI Musculoskeletal Network delegates also led a workshop titled Fracture liaison services – how do we do it in NSW.

What did we learn from others across the Globe?

- People who have fragility vertebral fractures have special needs, including:
  - Identification in radiology units – opportunistic diagnosis as these patients often don’t seek care for their back pain
  - Understanding the best treatments for vertebral fractures - what are the best treatments? Is spinal surgery part of the answer?

- The process Murrumbidgee LHD and Medicare Local is using to engage small rural towns in identifying osteoporosis is consistent with lessons learnt in the United Kingdom. The model of care delivery in Murrumbidgee includes offering opportunistic screening with the mobile Dual-energy X-ray (DXA) truck team engaged to visit townships and screen people at risk of osteoporosis as well as those who have sustained a minimal trauma fracture. The Fracture Liaison Coordinator (FLC) then follows up with the individuals several weeks later when results are received. The FLC also works with general practitioners and their teams to provide for individual care needs and community education.

- More focus should be placed on residential aged care facilities in providing bone health interventions including alerting them to FLC services that can support staff education and individual patient care.

- Surgeons should work closely with refracture prevention and primary care services, as the surgical process can impact on some of the long term care need of the patient.
For more information, contact the Network Manager.

Clinical Network Report

NUTRITION

Home Enteral Nutrition (HEN) Register

The ACI Home Enteral Nutrition (HEN) Register pilot project recently commenced at John Hunter Hospital, John Hunter Children’s Hospital, East Maitland Community Health Centre and Bankstown Hospital. Tamworth Rural Referral Hospital will also join the pilot project later this year.

The HEN Register is a web-based database designed to collect data on HEN patients, which will help to identify the scope and needs of people using HEN services in NSW. It can also be used to create HEN prescription letters for patients and nutrition companies, which will allow letters to be sent directly from the HEN register to the nutrition company via email, replacing other more complex methods of registration.

Project Officers Kim Gibson and Jacqui Hoggan are managing the pilot program and played a key role in the development of the HEN Register over the last two years.

The pilot will run for 12 weeks at each site, with the aim to determine:

- If the register is a useful tool for clinicians, managers and administrative staff to help improve the information they have about their HEN patients
- If the register requires any changes before being made available to other sites
- If the HEN register training program meets the needs of clinicians, managers and staff required to use the HEN register.

Staff at each site will receive training and will complete evaluation surveys before and after the pilot.

The ACI HEN Executive Committee would like to thank the ACI HEN Register Working
The Hon. Kevin Humphries, Minister for Mental Health, launches the Nutrition Standards for Consumers of Inpatient Mental Health Services in NSW. Photo: A Langton

New Nutrition Standards

The ACI Nutrition Network formally launched the new Nutrition Standards for Consumers of Inpatient Mental Health Services in NSW on 15 October 2013.

The Standards were developed by the ACI Nutrition and Mental Health Working Group, Co-Chaired by Jan Plain and Meg Vickery with significant support and input from Peter Williams.

People with mental illness are at significantly higher risk from chronic disease, particularly cardiovascular disease, which results in a reduced life expectancy. They also have much longer lengths of stay. A cornerstone of the Standards is the recognition that people accessing inpatient mental health services have clinical and social needs that differ to those of the general hospital population.

The development of the Standards was also informed by a qualitative review conducted by members of the Official Visitors (OVs) Program. OVs collected feedback from consumers and staff from inpatient mental health facilities across NSW during their duties.

The Standards aim to ensure that menus in inpatient mental health facilities provide the opportunity for people to select food that satisfies their nutrient requirements and supports their recovery. They include overarching principles that support a person-centered food and nutrition approach.

Some of the most significant new features of these Standards, which differ from the existing Nutrition Standards for Adult Inpatients in NSW Hospitals, are:

- Inclusion of a referenced summary of the major nutrition issues of particular relevance to people with mental illness
- New standards to define the minimum variety to be offered on menus
- Requirements to provide more high fiber bread and breakfast cereal options and foods with a low glycemic index at each meal
- Limits to the energy content of main menu items and mid-meal snacks
- A standard for the maximum time between supper and the breakfast meal service
- Additional goals for the magnesium and long chain n-3 fatty acids content of menus
- Advice on the availability of caffeinated beverages in mental health facilities.

The *Nutrition Standards for Consumers of Inpatient Mental Health Services in NSW* was formally launched by the Hon. Kevin Humphries, Minister for Mental Health, Minister for Healthy Lifestyles and Minister for Western NSW.

The ACI Nutrition Network sincerely thanks all members of the Nutrition and Mental Health Working Group, the Official Visitors, the NSW Consumer Advisory Group (Mental Health) and everyone who commented on draft versions of the Standards.

![Participants at the launch of the Nutrition Standards for Consumers of Inpatient Mental Health Services in NSW. Photo: A Langton](image)

**Nutrition Care Survey**

The ACI Nutrition in Hospitals Committee, under the guidance of the NSW Health Nutrition and Food Committee (NFC), has developed an online survey to determine how well NSW health care facilities meet the 'implementation' requirements of the NSW Health Nutrition Care Policy Directive (PD2011_78).

The survey was recently circulated to Local Health Districts (LHDs) and Specialty Networks (SNs). Each NSW public hospital facility is requested to complete the survey, which will also provide the opportunity to describe and share the successes and challenges related to implementation.

Results will be used by the Network to identify areas where LHDs and SNs need further support to implement the policy directive and will inform current and future initiatives of the Network.

Reports will be provided to LHD and SN Chief Executives and the NSW Health NFC. A summary will be made available on the ACI website in early 2014. For more information, contact the Network Manager.
New Co-Chair

Welcome to Joanna McCulloch, Transitional Nurse Practitioner (Ophthalmology), who has been appointed as the new Co-Chair of the Governing Body of the ACI Ophthalmology Network.

Joanna undertook her ophthalmic training at Moorfields Eye Hospital in London and currently works at Sydney/Sydney Eye Hospital. She has been involved in the Network since its establishment as the representative of the Australian Ophthalmic Nurses Association both on the Governing Body and as Chair of the Nurse Standing Committee.

Joanna has been actively involved in the development of the consensus eye emergency clinical guidelines published in the Eye Emergency Manual and the eye emergency education modules used in workshops to educate emergency department clinicians. She is a strong supporter of multidisciplinary education for eye emergencies and is involved in the review and development of a revised format for eye emergency education.

Stroke and Vision Defects Screening Tool Study

The Ophthalmology Network has agreed to provide funding for Phase 1 of the Stroke and Vision Defects Screening Tool Study. The Study will validate the Screening Tool (the Tool) developed by the Stroke and Vision Defects Working Group of the Orthoptic Standing Committee.

Phase 1 is a collaboration between the ACI Ophthalmology Network and the University of Sydney. It will be undertaken over a period of twelve months and will involve more than 100 patients who have had a stroke and are capable of responding to an assessment using the Tool. Two stroke patient cohorts (each numbering 50) will be recruited from two metropolitan hospital stroke units which currently do not have access to on site eye services and assessed to validate the effectiveness of the Tool. For more information, contact the Network Manager.

Eye Emergency Clinician Education Project

In 2008, the ACI Ophthalmology Network (then part of the Greater Metropolitan Clinical Taskforce (GMCT)) funded an Eye Emergency Clinician Education Project to develop and deliver an education program based on the consensus eye emergency clinical guidelines published in the Eye Emergency Manual in 2007.

The project aimed to improve assessment and management of patients presenting to NSW hospital emergency departments with eye problems. Education was provided by senior ophthalmic nurses from Sydney/Sydney Eye Hospital and local ophthalmologists.

To date, there has been:

- 24 metropolitan workshops
- 24 rural workshops
- Four (4) Train the Trainer workshops
- More than 350 medical staff attend
More than 563 nursing staff attend

Funding for the Project was fully expended in December 2012, with the Network opting to fund a final round of workshops for 2013. The final workshop for the Project was held at Campbelltown Hospital on 20 September with twenty participants.

Eight Eye Emergency power point presentations have been developed for self-directed learning and are available on the Ophthalmology Resources page of the ACI website.

The Network would like to thank all educators (senior ophthalmic nurses and ophthalmologists) and local clinicians who have very generously given up their time over the last five years to educate emergency clinicians and general practitioners about eye emergencies and ensure the success of the workshops.

New Chronic Care Network

The ACI is pleased to announce the establishment of a new Chronic Care Network. The new Network will provide expert advice and recommendations about opportunities to improve care across the life course for people with chronic disease in NSW and will consider broader issues of care for people with chronic and complex conditions.

The Chronic Care Network will collaborate closely with existing ACI Clinical Networks including the Cardiac, Respiratory, Endocrine and Renal Networks and the Primary Care and Chronic Services Portfolio Networks to reduce duplication and better integrate care across the system.

The ACI is inviting anyone with an interest or expertise in chronic care to join the Network. Network membership is open to clinicians, managers, consumers, carers, representative of non-government organisations and researchers from across NSW.

Interim Co-Chairs and a representative Executive Committee of 15-16 Network Members will be appointed to provide strategic leadership and guidance to the Chronic Care Network. Susan Brownlowe, Manager, Chronic Care has been appointed as the Network Manager to support Network activities and working groups.

To join the Chronic Care Network, please complete the membership application form or use the the ACI join a network form. For more information about the Network and a copy of the draft Terms of Reference, please contact Sue Brownlowe on ph: 02 9464 4681 or email: susan.brownlowe@aci.health.nsw.gov.au.

Chronic Disease Management Program Governance

The new Chronic Care Network is being established in conjunction with changes to the governance of the NSW Chronic Disease Management Program – Connecting Care in the Community (CDMP). These changes include:

- The Program Steering Committee (PSC) is being reconvened by the ACI with high level representation from Local Health Districts (LHDs) and Specialty Networks as the strategic and decision-making body for CDMP.
The Evaluation Steering Committee (ESC) is being reconvened to provide advice to the external evaluation consortium led by the George Institute for Global Health. The ESC will be chaired by the NSW Ministry of Health and the ACI will provide secretariat support.

The establishment of the Chronic Care Network also formalises existing advisory bodies for CDMP. Members of the CDMP Implementation Network, Chronic Disease Management Forum, and Non-Government Organisation Roundtable will be invited to become members of the Chronic Care Network. In addition, the CDMP Implementation Network will become a permanent Working Group of the Chronic Care Network to recognise the skill and expertise of members in supporting the ongoing implementation and development of the CDMP. The CDMP Implementation Working Group will advise and make recommendations to the PSC.

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**Australian Disease Management Association Conference 2013**

The ACI was proud to support the 9th Annual National Australian Disease Management Association (ADMA) Conference, *CDM: Innovation, Adaptation and Evolution*, which was held at the InterContinental in Sydney on 22 and 23 August 2013. The ADMA conference is the premier national conference to showcase interventions and innovations in chronic disease management. It was attended by more than 250 delegates, most of whom rated the content, presentations and organisation as very good to excellent.

The ACI was particularly pleased to offer scholarships to support consumers, clinicians and managers from Local Health Districts, Specialty Networks and Medicare Locals to attend the conference.

ACI and NSW initiatives featured in the pre-conference workshops and the conference program. Highlights included a panel discussion on the role of the General Practice and specialists in chronic disease management, presentations on the NSW Chronic Disease Management Program, NSW Knockout Health Challenge, Osteoarthritis Chronic Care Program and Chronic Pain. The ACI was also involved in organising *The Aged and Chronic Care Interface: Capitalising on the Best of Both Worlds and Program Evaluation in the Real World – Why? For Whom? How to do it?* preconference workshops, which both generated significant interest and discussion.

Thank you to everyone who participated in the conference.

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The Aged and Chronic Care Interface Workshop. Photo: R Osten

**Reforming Healthcare Systems Workshop**

The ACI hosted a workshop with the international speakers from the ADMA.
Conference on Wednesday, 21 August 2013. The workshop was themed Reforming health care systems to meet the challenges of ageing populations and allowed representatives from the ACI, NSW Ministry of Health and other Pillars who were unable to attend the full conference to hear from international speakers including:

- Nick Goodwin, Chief Executive Officer, International Foundation for Integrated Care (IFIC), United Kingdom.
- Mark Newbold, Chief Executive, Heart of England National Health Service Foundation Trust, United Kingdom.
- Alicia Arbaje, Assistant Professor of Medicine, Director of Transitional Care Research Division of Geriatric Medicine and Gerontology, Johns Hopkins University School of Medicine, United States.

The keynote speakers explored the challenges and opportunities associated with developing integrated care and providing more care outside of the hospital during their presentations at the workshop. A very interesting panel discussion about measures of quality that reflect person-centred care, the necessity of leadership and cultural change, and the role of electronic health records was also held following the keynotes. For more information, contact the Program Manager, Primary and Chronic Care.
Medical Imaging District Services

The ACI has appointed O’Connell Advisory to assist in the development of an Implementation Toolkit for Local Health Districts (LHDs) wishing to implement the Medical Imaging District Services (MIDS) business model. The model is based on:

- the recognition that Medical Imaging services are under increasing pressure to perform increasing volumes and complexity of procedures in a timely manner with resourcing constraints
- the known variety of approaches to the management of Medical Imaging across NSW Health
- the recognised need for support to be provided to successfully implement change within NSW Health, i.e. the MIDS Implementation Toolkit.

Hospital site visits as well as interviews with organisations such as NSW Health Pathology and the Royal Australian and New Zealand College of Radiologists were undertaken in September to assist in the compilation of a practical and realistic Toolkit. For more information on the development Toolkit, contact the Network Manager.

Network Manager

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Rehabilitation Model of Care Implementation Project

The ACI continues to support five Local Health Districts (LHDs) to implement the Rehabilitation Model of Care in their chosen care setting.

Local implementation teams have examined the 'as is' state for rehabilitation services and are busy finalising their implementation plans. Current progress at the sites includes:

- Hunter New England LHD is developing the Inreach Model of Care at the Newcastle campus as well as enhancing their inpatient services at Tamworth Hospital through the implementation of the Enablement Model of Care.
- Northern NSW is also looking to implement an Inreach Model of Care to support the provision of early rehabilitation to their patients while in the acute hospital.
- Nepean Blue Mountains have chosen to develop a day hospital in the Nepean area which will allow patients with ongoing rehabilitation needs to be managed in the community.
- The hub and spoke model is favoured by both Western NSW and Murrumbidgee who are working to ensure that patients are treated as close to home as possible.

Business proposals are currently being developed and will incorporate an analysis of the benefits of implementation from the ACI Health Economics and Analysis team. For more information, contact the Network Manager.

Goal Training Workshops

Feedback from attendees of the Rehabilitation Goal training workshops has been very positive. Comments include

"I thought the content was fantastic and am very excited about implementing these principles in my work"

and

"I am finding that the clients are more engaged with their rehabilitation which is improving patient outcomes. It is very rewarding."

The training focuses on developing patient centred goals and recognises that patients should be actively engaged in their healthcare journey through the setting of participation level rehabilitation goals. Workshops will be run during October and November in various locations across the state, with registration available on the ACI website.

Renal Supportive Care Survey

Results from a recent survey of NSW renal units have demonstrated variation in the availability of services to support symptom management for patients with end-stage kidney disease (ESKD).
Overall, 34 responses to the survey were received from nine medical, 14 nursing and 11 allied health professionals representing approximately half of all NSW renal units. The responses indicated that:

- Less than half of the responding units had any structured program in place to manage dialysis patients with persistent symptoms or to assist decision making around choosing dialysis versus a non-dialysis management pathway.
- Two-thirds did not have a structured end-of-life pathway for patients with ESKD.
- The information is inadequate for most units to know what proportion of ESKD patients are managed by a non-dialysis pathway.
- Only 15% of units felt they had sufficient staff to provide the best possible supportive care and symptom management.
- The majority felt that renal supportive care (RSC) for patients who choose a non-dialysis pathway cannot be delivered within existing nephrology clinic visits.
- There would be support for a visiting renal palliative service to rural areas, if available.
- The vast majority of staff currently employed in renal units do not have sufficient training and expertise to provide optimal conservative care and symptom management.

A RSC working group has been considering a workable solution and has developed a draft proposal to address these issues. The draft proposal will be circulated to renal and palliative care clinicians during October 2013 for feedback. For more information on this proposal, please contact the Network Manager.

### Measuring Home Dialysis Treatments

With the introduction of Activity-Based Funding (ABF) throughout NSW it has become necessary to remove the guesswork from how many treatments are provided at home.

Home-based dialysis services are used by around 1,300 patients in NSW, costing between $30,000-$35,000 per patient per year. Information on when patients start and stop these treatments, including periods when they may be in hospital, was not captured accurately in the past. The provision of this information is now a requirement of the ABF model in order to receive the appropriate funding for these services. To facilitate the collection of this information, the ABF Taskforce worked with the ACI Dialysis Working Group to create a spreadsheet to capture the occasions of service for patients receiving dialysis. This information will now be submitted monthly to the national body.

### Arterio-Venous Fistula Haemorrhage Project

The Arterio-Venous Fistula (AVF) Haemorrhage resources developed by the Renal Network have been well received across Australia and internationally. The resources are available on the ACI website and are listed under [[Renal Resources](https://www.aci.health.nsw.gov.au/networks/renal)]. An e-learning module for AVF Haemorrhage is now also available for renal nurses via the [Nephrology Educators’ Network (NEN)](https://www.aci.health.nsw.gov.au/networks/renal).

### Renal Advanced Trainees

The nephrology training requirement for renal advanced trainees has been increased from two core years to three core years for students commencing from 2014.

All seventeen vacant advanced trainee positions for 2014 were filled following interviews held at the Royal Australian College of Physicians on 4 September 2013. Ten of these placements went to first year advanced trainees who will commence
the three years' mandatory training requirement as announced by the Specialist Advisory Committee (SAC) earlier this year.

Representatives from all NSW Nephrology Departments have been invited to attend a meeting arranged by ACI Renal Network on Monday, 25 November 2013. Discussions will centre on requirements for the third year of training and how to meet needs of both trainees and renal units. For more information, please contact the ACI Renal Network Manager.

Clinical Network Report

RESPIRATORY

Implementing the Tracheostomy Care Guidelines

A series of Tracheostomy Care Implementation Workshops will be held for clinicians and managers across NSW.

Members of the ACI Tracheostomy team led by Kaye Rolls (ICCMU), Melissa Tinsley (Program Design and Implementation) and Cecily Barrack (Respiratory Network) will co-present the workshops in conjunction with local clinical leads.

The aim of each workshop is to:

- Provide local clinicians and managers with an overview of how team-based tracheostomy care can be organised at the facility level
- Support facilities to develop an approach to team-based care that is appropriate to their case mix
- Develop a community of practice to facilitate knowledge and information sharing at the local level

Register for the workshops. For further information please contact the Network Manager.
Delivering an integrated Spinal Seating Education Program in NSW - Outcomes and Challenges

Charisse Turnbull, Occupational Therapist, Assistive Technology and Seating (ATS) Service recently presented a paper on the progress of the Spinal Seating Professional Development Program (SSPDP) since completion of the Greater Metropolitan Clinical Taskforce funded project in early 2009, at the 2013 Australian and New Zealand Spinal Cord Society Conference.

The project had two important outcomes. The development of:

1. A comprehensive ten part spinal seating education online series, which was made available on the ACI State Spinal Cord Injury Service (SSCIS) web pages on completion. Web monitoring shows that these modules accounts for 10% of the total hits to the ACI website with these being the most visited webpages on the site, highlighting the interest in this area by those visiting the website.

2. A skill development workshop to help clinicians translate knowledge into practical assessment skills.

Since 2009 the workshops have been provided by the ATS Service of NSW to meet the ongoing demand from clinicians required to prescribe seating and mobility technologies to people with a spinal cord injury. Ten one-day workshops have been conducted, five of these in rural NSW locations, and were attended by more than 157 prescribing clinicians. Clinicians are required to complete all of the online modules prior to attending the workshop.

Evaluation feedback from workshop participants highlights the following ongoing needs:

1. Monitoring and updating of web modules in line with new clinical practice guidelines and advancements in seating and mobility technologies

2. Development of intermediate level workshops to help clinicians update and further expand their skills and knowledge

3. Mentorship and supervision strategies to support clinicians needing to translate their seating assessment findings into intervention plans and prescriptions. To date this has occurred on an informal basis when clinicians contact ATS to seek further advice or help either in Sydney or during rural outreach seating clinics.

Evaluation from workshops participants has highlighted the value the SSPDP and workshops to clinicians who wish to develop baseline seating and wheeled mobility assessment and trouble-shooting skills.

ATS are currently investigating telehealth options, opportunities and resources as a way of extending the limited services to provide timely and cost effective seating consultation to clients and local clinicians who are in rural and remote areas of NSW. Telehealth consultation and treatment sessions also provide opportunities for mentoring and education relevant to the clinician's caseload. For more information, contact the Network Manager.

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Record Numbers Attend Stroke Education

More than 270 clinicians from across the Southern NSW Local Health District (LHD) and ACT Health attended the stroke education sessions hosted by the ACI Stroke Network in Merimbula and Moruya during September.

The education sessions, coordinated by Catherine Barkley and Robin Grenenger, focused on the stroke patient journey from onset, triage by NSW Ambulance Service paramedics, Emergency Department and through the acute inpatient and rehabilitation care delivery experience.

Supported by Southern NSW Medicare Local, the event combined two clinical education sessions per day (multidisciplinary and general practice) and a consumer forum hosted by the Stroke Recovery Association of NSW.

Merimbula Stroke Education session panel discussion members. Photo: M Longworth

Feedback from the education sessions has been extremely positive. For more information, please contact the Network Manager.

Unwarranted Clinical Variation in Ischaemic Stroke

The Unwarranted Clinical Variation in Ischaemic Stroke Expert Reference Group has now completed a data review, engagement with LHDs, clinical audits and hospital visits.

The Group commenced the program following a combined ACI and Bureau of Health Information Clinical Variation workshop in April 2013. Six hospitals (Lismore, Bateman's Bay, Wagga Wagga, St Vincent's, Manly and Royal Prince Alfred) were chosen to undergo clinical audit using a revised ACI Stroke Network patient outcome focused audit tool.

John Worthington presented the results of the audit, which were analysed through the Florey Institute (Monash University, Victoria), to the Unwarranted Clinical Variation Taskforce on 3 September 2013. Recommendations from the analysis include the Group:

- Develops a project team to continue the process of audit and feedback
- Continues the expansion of the stroke network to engage with the LHDs that do not have organised stroke services
Continues engagement with the BHI on the reporting of stroke outcomes in NSW

- Improves data collection and performance reporting around stroke thrombolysis
- Undertakes a further Clinical Variation workshop in 2014

In summary, ACI Stroke Network Co-Chair John Worthington noted:

"Unwarranted clinical variation in stroke is explicable variation. At present stroke patients do not always receive evidenced-based care. This may be the result of being admitted to a smaller hospital with no organised stroke care and little prospect of providing it, admission to a hospital where stroke unit care could reasonably be provided but no unit has been established, because a patient fails to reach a stroke unit bed in a hospital with a stroke unit or because of variations in the quality of care where organised stroke care exists."

Clinicians and administrators from Wagga Wagga Base Hospital. Photo: M Longworth

Clinical Network Report

TRANSITION CARE

Regional Transition Events

Angie Myles, Northern Region Transition Coordinator, recently held a transition booth at the Hunter Post Graduate Medical Institute (HPMI) General Practitioner (GP) Update Weekend in Newcastle.

This event provided Angie with an opportunity to network with GPs, practice nurses and other clinicians from the region and to build awareness of the ACI Transition Care Network and its activities. She also provided information on transition at the NAIDOC Family Fun Day held in Newcastle on 25 September to showcase Aboriginal Culture and achievements, provide access to information about cost free services and also create an opportunity to socialise and raise awareness within the broader community of Aboriginal concerns.

In August, Angie presented to nursing staff attending a diabetes workshop in Newcastle and met with paediatric nursing staff at Coffs Harbour Base Hospital. She also presented to generalist and mental health nurses attending Hunter New England Local Health District's Diabetes Management in the General Care Setting four day course held recently in both Newcastle and Forster. Her presentation discussed the specific issues and needs of young people with chronic medical conditions transitioning to adult health services.
Patricia Kasengele, Transition Care Coordinator for Western Area has also been visiting regional areas and in late September presented on transition to Care West and CP Alliance in Orange.
Where: Glasshouse, Port Macquarie, New South Wales
When: Monday, 21 – Wednesday, 23 October 2013

The Health Education and Training Institute (HETI), Australian Rural Health Research Collaboration and NSW Health are proud to present the 2nd NSW Rural Health and Research Congress to be held at the Glasshouse Port Macquarie 21st - 23rd October 2013.

The Congress, held each year in a rural NSW location, provides health staff and researchers with an opportunity to attend a high quality forum which brings together the latest information on rural health.

Delegates come from a wide range of backgrounds including nursing, medical, allied health, ambulance, clinical researchers, academia, administration and the private health sector. Last year's Congress in Wagga Wagga proved to be a great success and we're planning for Port Macquarie to be just as good.

The Congress theme for 2013 - "Innovation and Achievement: making the difference in rural health" - will explore how rural health services, research organisations and associated agencies use innovative solutions to address the health challenges faced by rural people.

ACI Awards for Innovation

One Congress highlight will be the presentation of the Agency for Clinical Innovation (ACI) 2013 "Awards for Innovation". The ACI are introducing three Innovation Awards, to the value of $1,000 each to promote and highlight the value of innovation in rural clinical practice, and complement the Congress theme.

Award categories, available to projects presented in Concurrent Sessions, are:

- **Best small facility / MPS Project**
- **Most creative / innovative**
- **Most transferable or system-wide potential**

Selection criteria will be based on projects which demonstrate resourcefulness and creativity in design, sustainability in embedding the change and the potential to be taken up by other health settings or a system-wide priority in health. The three awards are to be used by the project team, at the discretion of their organisation,
to add value to the project and contribute to its sustainability.

For more details visit the Congress website.

CONTACT US/ FEEDBACK

We appreciate hearing from you - please contact:

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LETTERS TO THE EDITOR

Readers of Clinician Connect are invited to submit letters for publication. These can relate to topics of current clinical interest or items published in the ACI newsletter. All Letters to the Editor must have a name, address and telephone number to be used for verification purposes only. The submitter’s name, title and organisation will be used in print. No anonymous letters will be printed. The ACI reserves the right to edit all letters and to reject any and all letters.

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