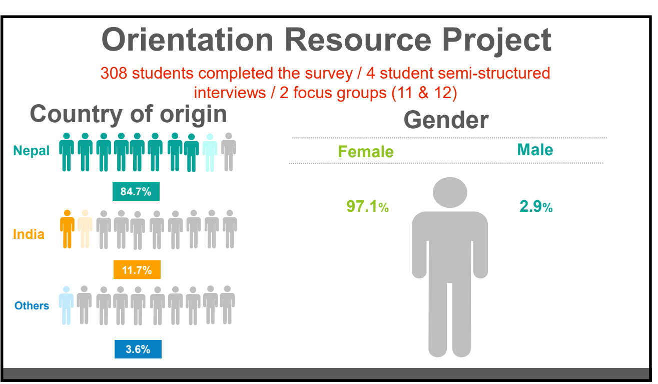
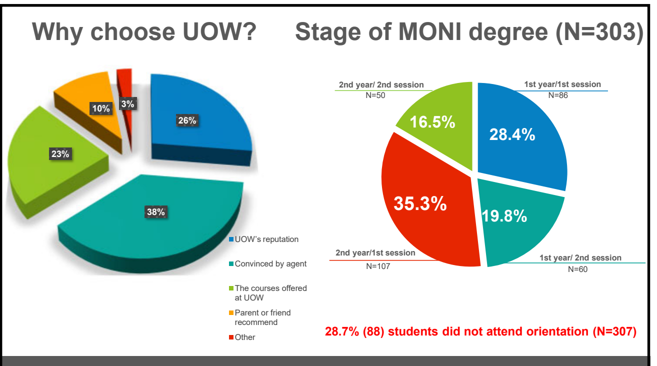
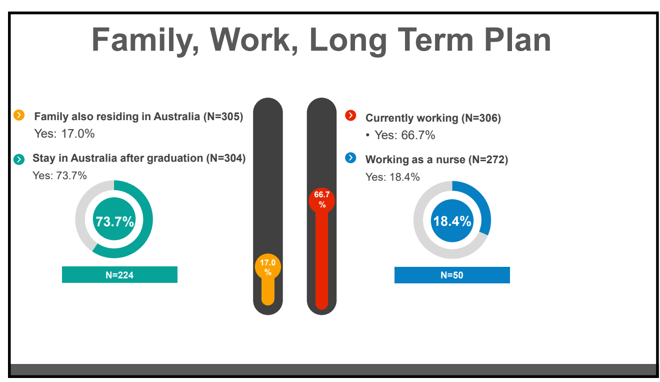






What New International Students Want

Appropriate and timely support across the entire student life cycle

Student comments

'I stood and cried in the middle of campus'

'I was so overwhelmed. I didn't know how to get the subject content'

'I was in my 2nd year before I realised the degree did not lead to RN qualification'

'A kind person in the library noticed I was upset and helped me'

What International Students Want

Appropriate and timely support across the entire student life cycle

How will the degree benefit me?

Does it lead to Nurse Registration?

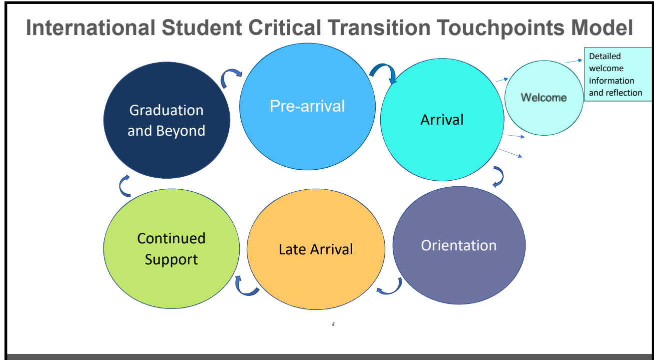
'How to set up my schedule/workshops'

'Access my SOLS/Moodle site/mail'

'Orientation for late arrival students'

'Support when I need it'

International Student Critical Transition Touchpoints Model

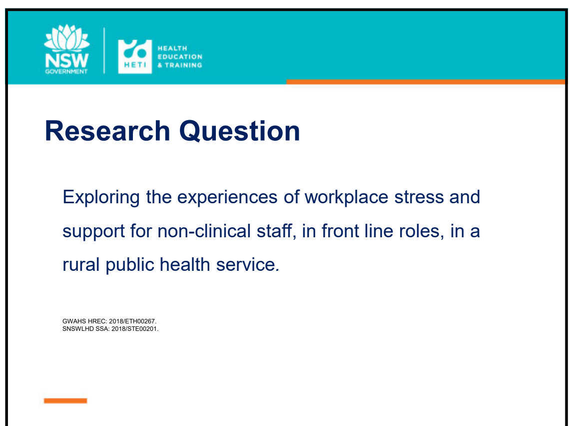


The Resource

School of Nursing website
Recruitment Agents
International page of the UOW Website

https://www.uow.edu.au/science-medicine-health/international/international-student-orientation/

WHERE INNOVATION DRIVES
EXCELLENCE IN EDUCATION AND TRAINING
FOR IMPROVED HEALTH OUTCOMES
'But that's their Job':
Exploring workplace experiences
of frontline non-clinical staff.
Researcher: Tracy Bolton - Social Worker
Southern NSW Local Health District
This research has been funded and supported by the HETI Rural Research Capacity Building Program
HETI.NSW.GOV.AU
@NSWHETI
COMPANY/HETI
NSWHETI

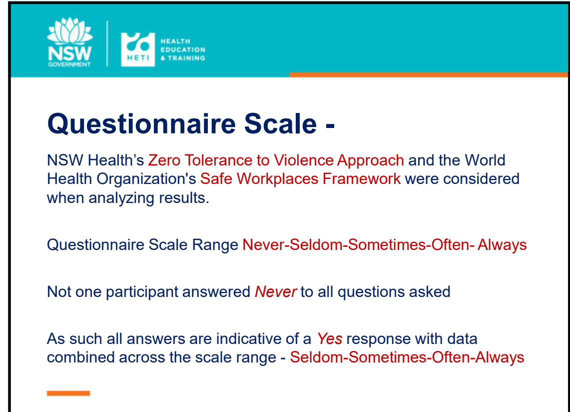

Research Question
Exploring the experiences of workplace stress and support for non-clinical staff, in front line roles, in a rural public health service.
GWAHS HREC: 2018/ETH00267.
SNSWLHD SSA: 2018/STE00201.

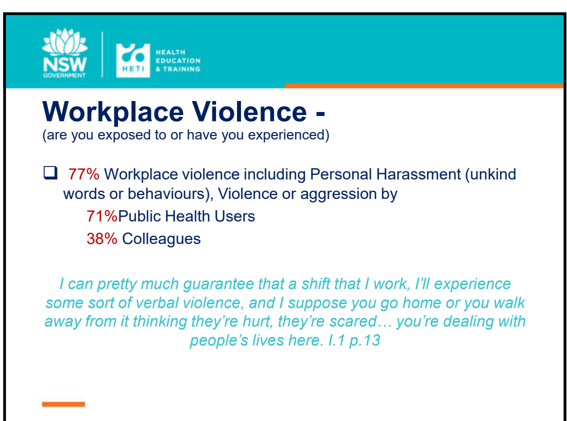
Study Design -
Study Design
Explanatory Sequential Mixed Methods
(Quantitative → Qualitative)
Questionnaire
Descriptive Analysis
Interviews
Framework Method Analysis

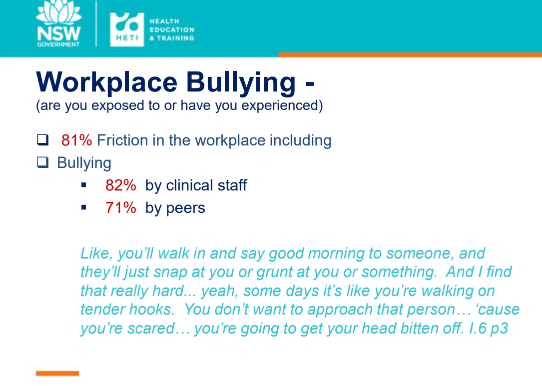
Participants –
(face to face or phone contact with public health users)
Aboriginal Health workers
Administration workers
Community Health Intake Workers
Health and Security Assistants
Health Information (medical records)
Patient Transport drivers
Wards men

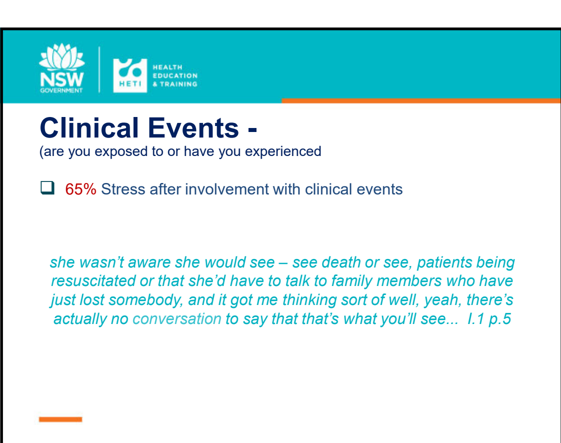
What did the research explore?
Exposure to or experience of:
Occupational violence
Bullying
Trauma after Clinical Event
Demand – Control – Support
Within their general roles activities
Situations outside of their role (including above)

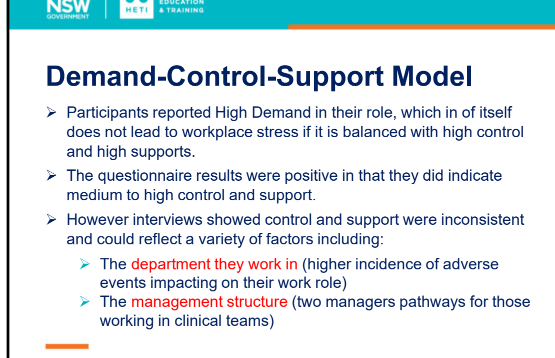
Data collected -
Total of 93 questionnaires sent out
34 questionnaires returned
6 participants participated in 1:1 interviews


Questionnaire Scale -
NSW Health's Zero Tolerance to Violence Approach and the World Health Organization's Safe Workplaces Framework were considered when analyzing results.
Questionnaire Scale Range Never-Seldom-Sometimes-Often- Always
Not one participant answered Never to all questions asked
As such all answers are indicative of a Yes response with data combined across the scale range - Seldom-Sometimes-Often-Always

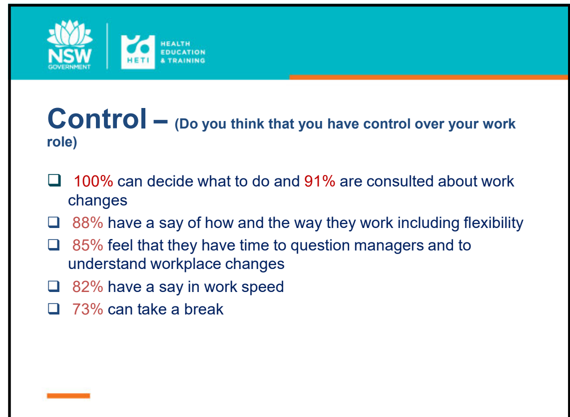

Workplace Violence -
(are you exposed to or have you experienced)
77% Workplace violence including Personal Harassment (unkind words or behaviours), Violence or aggression by
71%Public Health Users
38% Colleagues
I can pretty much guarantee that a shift that I work, I'll experience some sort of verbal violence, and I suppose you go home or you walk away from it thinking they're hurt, they're scared… you're dealing with people's lives here. I.1 p.13


Workplace Bullying -
(are you exposed to or have you experienced)
81% Friction in the workplace including
Bullying
82% by clinical staff
71% by peers
Like, you'll walk in and say good morning to someone, and they'll just snap at you or grunt at you or something. And I find that really hard... yeah, some days it's like you're walking on tender hooks. You don't want to approach that person… 'cause you're scared… you're going to get your head bitten off. I.6 p3


Clinical Events -
(are you exposed to or have you experienced
65% Stress after involvement with clinical events
she wasn't aware she would see – see death or see, patients being resuscitated or that she'd have to talk to family members who have just lost somebody, and it got me thinking sort of well, yeah, there's actually no conversation to say that that's what you'll see... I.1 p.5

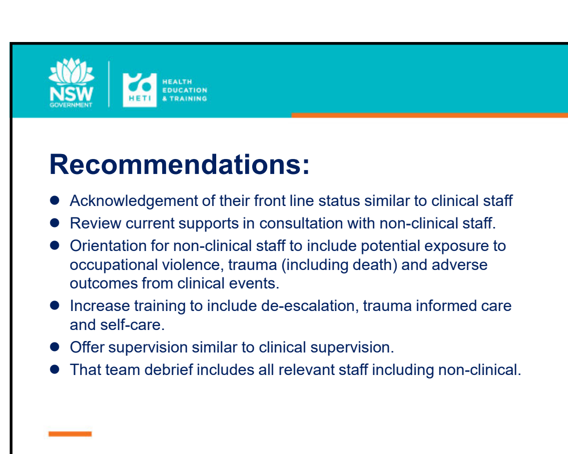

Demand-Control-Support Model
Participants reported High Demand in their role, which in of itself does not lead to workplace stress if it is balanced with high control and high supports.
The questionnaire results were positive in that they did indicate medium to high control and support.
However interviews showed control and support were inconsistent and could reflect a variety of factors including:
The department they work in (higher incidence of adverse events impacting on their work role)
The management structure (two managers pathways for those working in clinical teams)

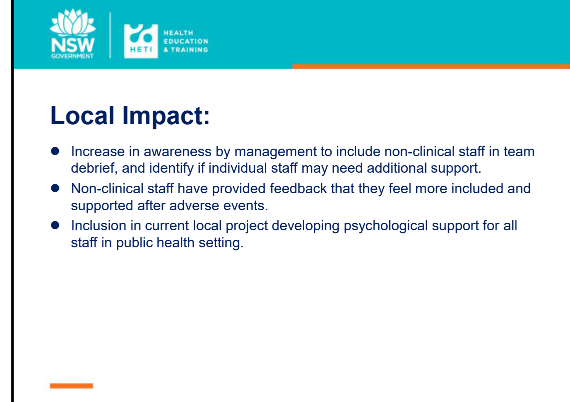
Demand – (Do you feel you can manage your work role demands)
100% of participants felt that different groups demand different things; they have to work very fast; and intensively
94% Neglect some tasks due to workload; and 91% unrealistic time pressures
88% felt they are unable to take sufficient breaks; and 85% have unachievable deadlines
While 79% feel they have to work long hours

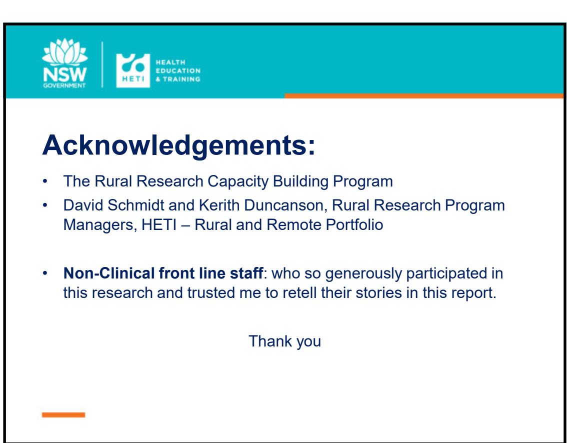

NSW GOVERNMENT
HETI HEALTH EDUCATION & TRAINING
Control – (Do you think that you have control over your work role)
100% can decide what to do and 91% are consulted about work changes
88% have a say of how and the way they work including flexibility
85% feel that they have time to question managers and to understand workplace changes
82% have a say in work speed
73% can take a break

NSW GOVERNMENT
HETI HEALTH EDUCATION & TRAINING
Support - (Do you feel you are supported in your work role)
91% received supportive feedback
82% feel respected by colleagues
79% feel supported by colleagues, line manager including when they are upset or annoyed about a work situation
73% are supported by colleagues who are willing to listen and provide help and support in emotionally demanding work

NSW GOVERNMENT
HETI HEALTH EDUCATION & TRAINING
Formal and Informal Supports-
(what supports do you access and what would you access if available)
Supports reportedly being accessed
94% family Peers 91%, Friends 79%
68% talk with clinical staff; and 62% team debriefing
44% Supervision; and private counselling
21% Employee Assistance Program
Supports they would access
88% Role specific training
68% Peer group or individual supervision
65% Mentoring Program


NSW GOVERNMENT
HETI HEALTH EDUCATION & TRAINING
Recommendations:
Acknowledgement of their front line status similar to clinical staff
Review current supports in consultation with non-clinical staff.
Orientation for non-clinical staff to include potential exposure to occupational violence, trauma (including death) and adverse outcomes from clinical events.
Increase training to include de-escalation, trauma informed care and self-care.
Offer supervision similar to clinical supervision.
That team debrief includes all relevant staff including non-clinical.


NSW GOVERNMENT
HETI HEALTH EDUCATION & TRAINING
Local Impact:
Increase in awareness by management to include non-clinical staff in team debrief, and identify if individual staff may need additional support.
Non-clinical staff have provided feedback that they feel more included and supported after adverse events.
Inclusion in current local project developing psychological support for all staff in public health setting.


NSW GOVERNMENT
HETI HEALTH EDUCATION & TRAINING
Acknowledgements:
The Rural Research Capacity Building Program
David Schmidt and Kerith Duncanson, Rural Research Program Managers, HETI – Rural and Remote Portfolio
Non-Clinical front line staff: who so generously participated in this research and trusted me to retell their stories in this report.
Thank you

NSW GOVERNMENT
HETI HEALTH EDUCATION & TRAINING
References:
Johnson, J. & Hall E. (1988). Job strain, work place social support , and cardiovascular disease: A cross-sectional study of a random sample of the Swedish working population. American Journal of Public Health, 78, pp. 1336 – 1342.
Karasek, R. (1979). Job demands, job decision latitude and mental strain: Implications for Job strain. Administrative Science Quarterly, 24, 285-308.
NSW Ministry of Health. (2015a). Preventing and Managing Violence in the NSW Health Workplace – A Zero Tolerance Approach, North Sydney, NSW, Australia.
World Health Organisation. (nd). Occupational Health Stress at the Workplace, World Health Organisation, http://www.who.int/occupational_health/topics/stressatwp/en
World Health Orgnisation (2002). Framework guidelines for addressing workplace violence in the health sector, World Health Organisation, available at www.who.int/iris/handle/10665/42617

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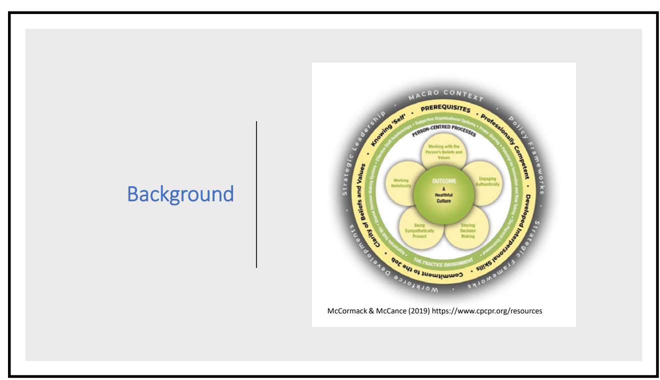
How does engaging authentically influence the development of healthful nurse-patient relationships? A scoping review of the literature

Helen Pratt PhD Candidate UOW
Acknowledgement to Supervisors:
Professor Tracey Moroney &
Dr Rebekkah Middleton

Background

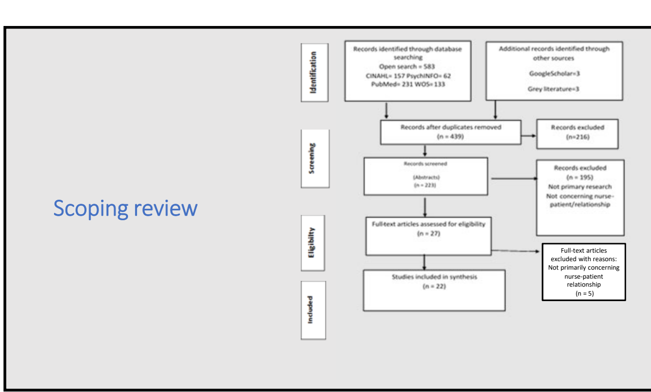


McCormack & McCance (2019) https://www.cpcpr.org/resources

Aim

The aim of this scoping review was is to identify empirical studies related to the nurse-patient relationship and the process of engaging authentically.

Scoping review



Themes from the literature

- ❖Getting to know the patient as a person
- ❖The complexity of relationship building- it takes time
- ❖The nurse: characteristics and behaviours that support the healthful nurse-patient relationship
- ❖The patients' voice

Where to from here?

What does engaging authentically look like, sound like and feel like in the nurse-patient relationship

What are the benefits and what are the challenges of engaging authentically for nurses and patients?

Background

- Modifiable lifestyle risk behaviours have led to increases in chronic disease.
- GPNs are ideally placed to support lifestyle risk reduction.
- Why are interactions important?
- Study Aim

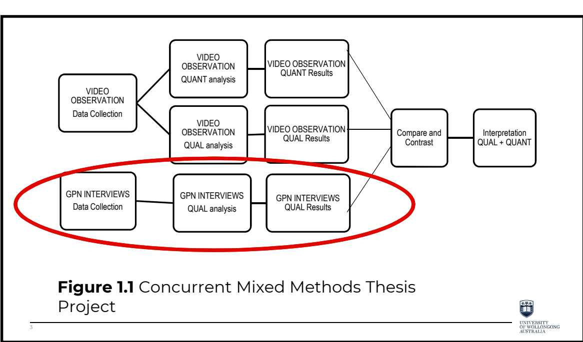
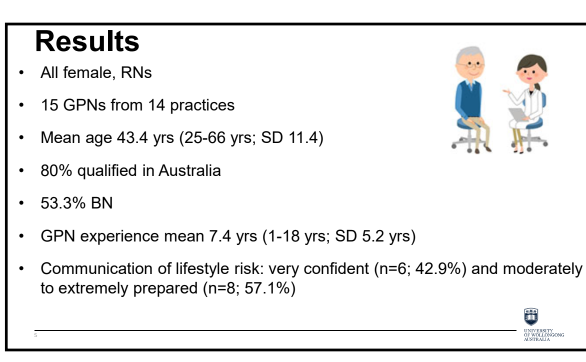
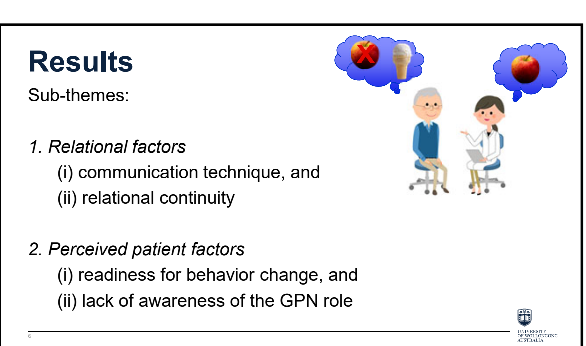


Figure 1.1 Concurrent Mixed Methods Thesis Project

Methods

- Semi-structured interviews with verbatim transcription.
- 15 GPNs.
- Interviews conducted often the same day as video recording.
- Thematic analysis informed by Braun & Clarke (2006).
- NVivo Version 11 used in analysis.





1. Relational factors

i) Communication technique

“Try and meet them in a normal kind of realistic way, ... they're a bit more onboard for listening to what you might have to say then thereafter." (Susan)

ii) Relational continuity

"I think they generally feel more comfortable with a nurse. I guess because they've had contact with them in the past …. one on one they talk better and they've got more time with you as well." (Diana)

2. Perceived patient factors

i) Readiness for behaviour change

“....some people are quite motivated and they will come and see you because they are very ready to do something about whatever it is.......some are just there because they want their five visits to the podiatrists to get their feet done for the year.” (Pat)

ii) Lack of awareness of the GPN role

“They don't know why the doctor's booked them in with us or why we've asked them to come in. Sometimes they are - sometimes they're just a bit suspicious, why are we asking all these questions. We just need to set a parameter around why we're doing it and the benefits that we're trying to achieve from it.” (Tina)

Discussion and Conclusion

- Interactions supporting lifestyle risk communication
- Barrier resolution
- Mechanisms for communicating and better utilising the GPN role in lifestyle risk reduction

- A big THANKYOU to the nurses and practices who participated in the study!

Project References so far

- James, S, McInnes, S, Halcomb, E & Desborough, J 2020, 'Lifestyle risk factor communication by nurses in general practice: Understanding the interactional elements', *Journal of Advanced Nursing*, vol. 76, no. 1, pp. 234-42.
- James, S, Halcomb, E, Desborough, J & McInnes, S 2019, 'Review: Lifestyle risk communication by general practice nurses: An integrative literature review', *Collegian*, vol. 26, pp.183-93.
- James, S, Desborough, J, McInnes, S & Halcomb, E 2019, 'Strategies for using non-participatory video research methods in general practice', *Nurse Researcher*, vol. 27, no. 2, pp. 32-7.

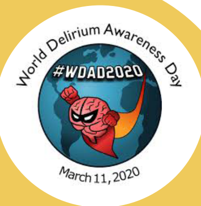
Key references

- Braun, V & Clarke, V 2006, 'Using Thematic Analysis in Psychology', *Qual Res Psychol*,3(2),77-101.
- Desborough, J, Phillips, C, Mills, J, Korda, R, Bagheri, N & Banfield, M 2018, 'Developing a positive patient experience with nurses in general practice: An integrated model of patient satisfaction and enablement', *J Adv Nurs*,74(3),564-78.
- Mason, P & Butler, C 2010, *Health Behavior Change; A Guide for Practitioners*, 2nd edn, Churchill Livingstone Elsevier United Kingdom.

THEME FOR 2020

LET'S STOP DELIRIUM BEFORE IT STARTS

prevention is key!



UNLOCKING THE ANSWERS TO PREVENTING DELIRIUM

FURTHER INFORMATION

If you have experienced delirium or concerned about a family member there is information online which can help you:

Australasian Delirium Association
https://www.delirium.org.au/community-info or

NSW Health through the Agency for Clinical Innovation
https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0018/181701/ACI-Delirium-Brochure.pdf

If you are a health practitioner take time to review the ACI resources https://www.aci.health.nsw.gov.au/chops

If you are a patient or your family member is in hospital do not hesitate to talk with the healthcare staff in the hospital about delirium.

In the community, contact your practice nurse or make an appointment with your General Practitioner

And if you have more time why not complete the new updated My Health Learning Delirium Care Module (Course Code: 266621954)

CONTACT FOR FURTHER INFORMATION

UOW: Professor Victoria Traynor: victoria_traynor@uow.edu.au
ISLHD: Professor Valerie Wilson: Valerie.Wilson@health.nsw.gov.au
ISLHD: Clinical Nurse Consultant: Miriam.Coyle@health.nsw.gov.au
SESLHD: Nurse Practitioner: Amy.Montgomery@health.nsw.gov.au
SNSWLHD: Clinical Nurse Consultant : Catherine.Bateman@health.nsw.gov.au

ADHERe.org.au | adhere-enquiries@uow.edu.au

A NEW RESOURCE LAUNCHED

LET'S IDENTIFY DELIRIUM EARLY AND IMPROVE PATIENT OUTCOMES

assessment is crucial!

... IN HOSPITALS

... IN NURSING HOMES

Link to our webpage to view the new delirium videos

WATCH OUR VIDEOS. LEARN HOW TO ASSESS FOR DELIRIUM IN ALL CARE SETTINGS USING THE 4AT AND CAM

... IN CLINICS

UNLOCKING THE ANSWERS TO IDENTIFYING DELIRIUM

LAUNCH OF NEW PROJECT

Our team are undertaking an internationally innovative nurse-led study funded by NSW Health to improve delirium patient outcomes in peri-operative care.

Over the next two years we are working with peri-operative and aged care practitioners at Wollongong, St. George and Bega Hospitals to identify strategies to improve delirium care.

This study builds on our previously successful research to develop new delirium care education and protocols in surgical, medical and aged care wards.

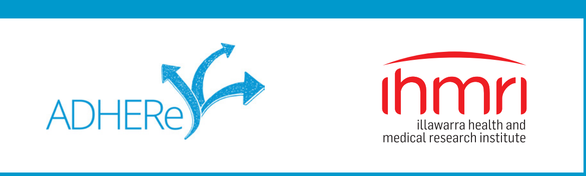
Understanding delirium improved my nursing care and I can help patients recover more quickly from their operation.

I now understand what is happening when I see delirium. I still need to learn more but at least I can identify it sooner.

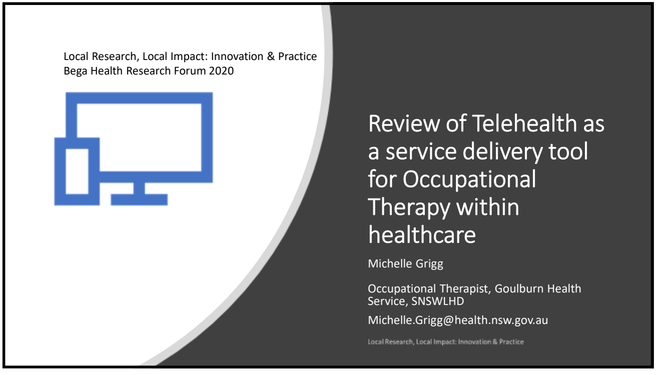
Our study will be promoted to other hospitals and contribute to improving the outcomes for patients who experience a post-operative delirium across NSW.

CONTACT FOR FURTHER INFORMATION ABOUT OUR RESEARCH

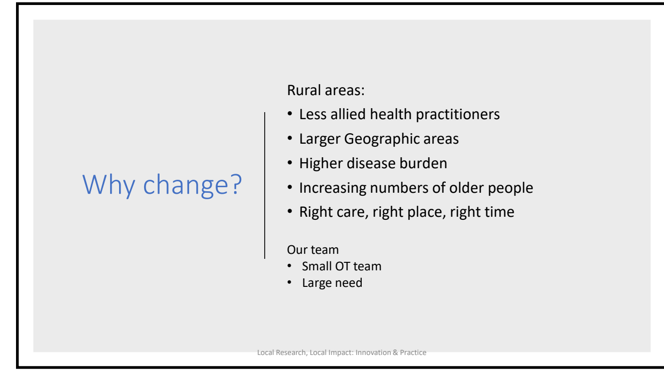
UOW: Professor Victoria Traynor: victoria_traynor@uow.edu.au
ISLHD: Professor Val Wilson: Valerie.Wilson@health.nsw.gov.au
ISLHD: Project Manager Clinical Nurse Consultant Alera Bowden: Alera.Bowden@health.nsw.gov.au
SESLHD: Nurse Practitioner Amy Montgomery: Amy.Montgomery@health.nsw.gov.au



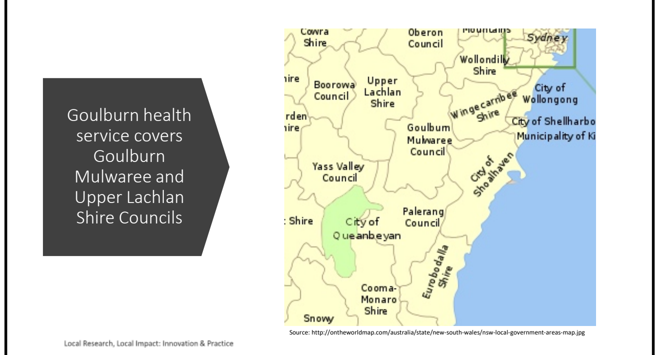
ADHERe.org.au | adhere-enquiries@uow.edu.au



Local Research, Local Impact: Innovation & Practice
Bega Health Research Forum 2020
Review of Telehealth as a service delivery tool for Occupational Therapy within healthcare
Michelle Grigg
Occupational Therapist, Goulburn Health Service, SNSWLHD
Michelle.Grigg@health.nsw.gov.au
Local Research, Local Impact: Innovation & Practice

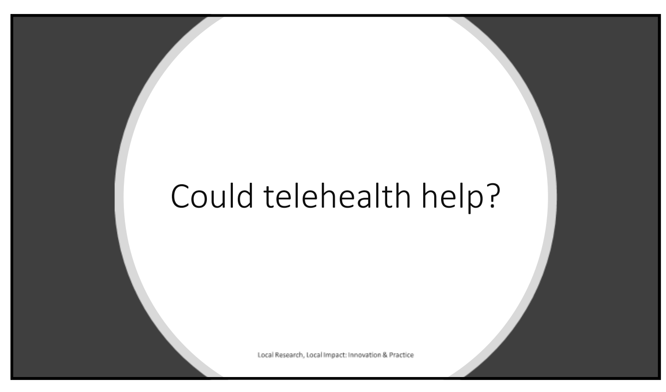


Why change?
Rural areas:
• Less allied health practitioners
• Larger Geographic areas
• Higher disease burden
• Increasing numbers of older people
• Right care, right place, right time
Our team
• Small OT team
• Large need
Local Research, Local Impact: Innovation & Practice

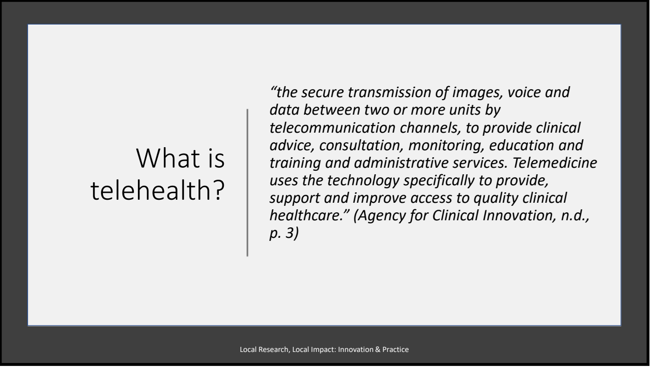


Goulburn health service covers Goulburn Mulwaree and Upper Lachlan Shire Councils
Cowra Shire
Oberon Council
Wollondilly Shire
Sydney
Boorowa Council
Upper Lachlan Shire
City of Wollongong
Wingecarribee Shire
City of Shellharbour
Goulburn Mulwaree Council
Yass Valley Council
City of Shoalhaven
City of Queanbeyan
Palerang Council
Eurobodalla Shire
Cooma-Monaro Shire
Snowy
Source: http://ontheworldmap.com/australia/state/new-south-wales/nsw-local-government-areas-map.jpg
Local Research, Local Impact: Innovation & Practice

Upper Lachlan Shire Council
Goulburn Mulwaree Council
Tuena
Bigga
Peelwood
Crooked Corner
Narrawa
Laggan
Taralga
Bevendale
Crookwell
Grabben Gullen
Wombeyan Caves
Mummel
Gunning
Collector
Local Research, Local Impact: Innovation & Practice
Source: google maps www.maps.google.com

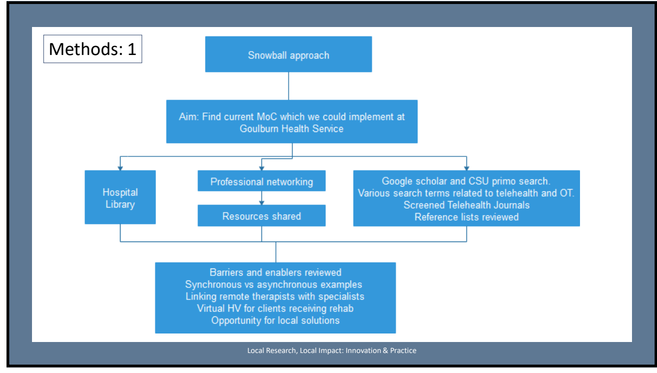


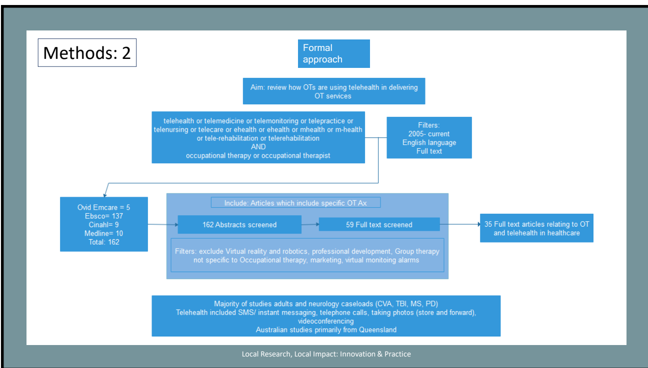
Could telehealth help?
Local Research, Local Impact: Innovation & Practice

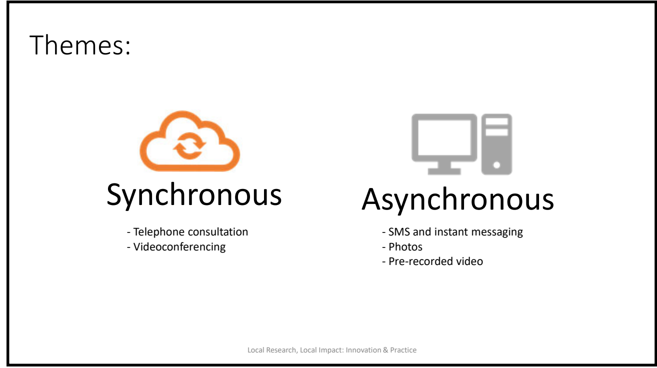


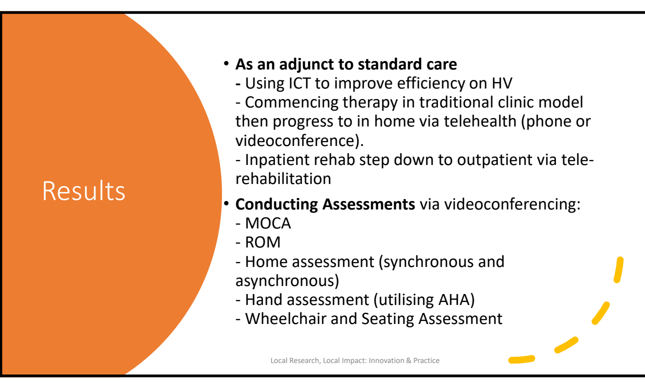
What is telehealth?
"the secure transmission of images, voice and data between two or more units by telecommunication channels, to provide clinical advice, consultation, monitoring, education and training and administrative services. Telemedicine uses the technology specifically to provide, support and improve access to quality clinical healthcare." (Agency for Clinical Innovation, n.d., p. 3)
Local Research, Local Impact: Innovation & Practice

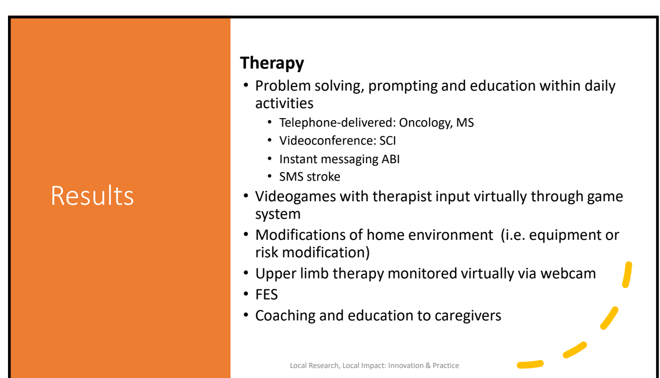
InformationCommunicationTechnology
TeleConsulting
Videoconferencing
TeleRehabilitation
TeleMedicine
Telecare
mHealth
ICT
eHealth
TeleTherapy
TelePractice
OnlineTherapy
TeleIntervention
TeleEvaluation
TeleSupervision
TeleMonitoring
Local Research, Local Impact: Innovation & Practice


Methods: 1
Snowball approach
Aim: Find current MoC which we could implement at Goulburn Health Service
Hospital Library
Professional networking
Resources shared
Google scholar and CSU primo search.
Various search terms related to telehealth and OT.
Screened Telehealth Journals
Reference lists reviewed
Barriers and enablers reviewed
Synchronous vs asynchronous examples
Linking remote therapists with specialists
Virtual HV for clients receiving rehab
Opportunity for local solutions
Local Research, Local Impact: Innovation & Practice


Methods: 2
Formal approach
Aim: review how OTs are using telehealth in delivering OT services
telehealth or telemedicine or telemonitoring or telepractice or telenursing or telecare or ehealth or ehealth or mhealth or m-health or tele-rehabilitation or telerehabilitation
AND
occupational therapy or occupational therapist
Filters:
2005- current
English language
Full text
Ovid Emcare = 5
Ebsco= 137
Cinahl= 9
Medline= 10
Total: 162
Include: Articles which include specific OT Ax
162 Abstracts screened
59 Full text screened
Filters: exclude Virtual reality and robotics, professional development, Group therapy not specific to Occupational therapy, marketing, virtual monitoing alarms
35 Full text articles relating to OT and telehealth in healthcare
Majority of studies adults and neurology caseloads (CVA, TBI, MS, PD)
Telehealth included SMS/ instant messaging, telephone calls, taking photos (store and forward), videoconferencing
Australian studies primarily from Queensland
Local Research, Local Impact: Innovation & Practice


Themes:
Synchronous
- Telephone consultation
- Videoconferencing
Asynchronous
- SMS and instant messaging
- Photos
- Pre-recorded video
Local Research, Local Impact: Innovation & Practice


Results
• As an adjunct to standard care
- Using ICT to improve efficiency on HV
- Commencing therapy in traditional clinic model then progress to in home via telehealth (phone or videoconference).
- Inpatient rehab step down to outpatient via tele-rehabilitation
• Conducting Assessments via videoconferencing:
- MOCA
- ROM
- Home assessment (synchronous and asynchronous)
- Hand assessment (utilising AHA)
- Wheelchair and Seating Assessment
Local Research, Local Impact: Innovation & Practice


Results
Therapy
• Problem solving, prompting and education within daily activities
• Telephone-delivered: Oncology, MS
• Videoconference: SCI
• Instant messaging ABI
• SMS stroke
• Videogames with therapist input virtually through game system
• Modifications of home environment (i.e. equipment or risk modification)
• Upper limb therapy monitored virtually via webcam
• FES
• Coaching and education to caregivers
Local Research, Local Impact: Innovation & Practice

Talking telehealth and OT in the Tablelands

- Opportunities:
  - Increase use telehealth among OT and other teams within community health at Goulburn
  - Virtual home visits with patients/ therapists in metropolitan hospitals
  - Increase and formalise use of photos to assist with discharge from hospital
  - Potential to develop telehealth service delivery model within OT at Goulburn Health Service

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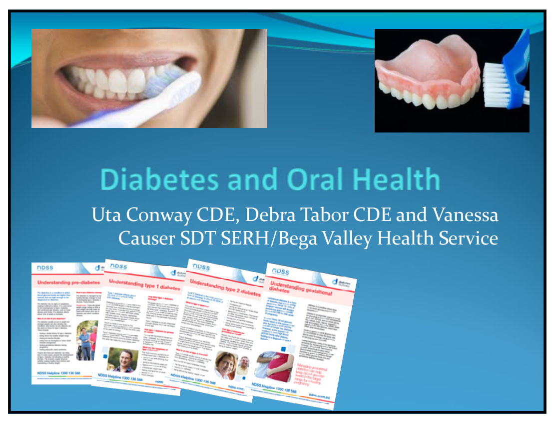
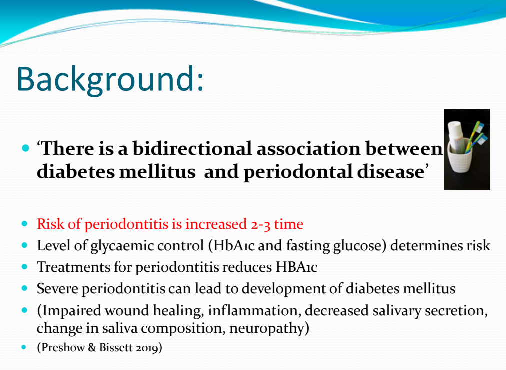
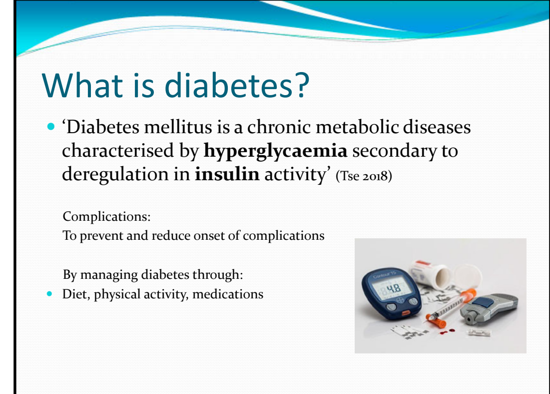






Need for project:

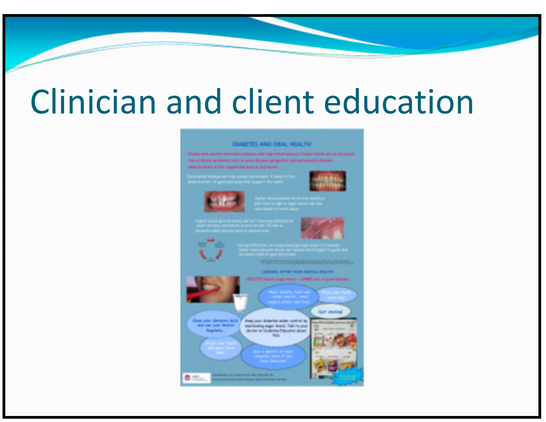
- Lack of awareness:
- Oral health is frequently overlooked as diabetes complication by clients (Poudel et al. 2017).
- Oral Health can be a neglected area of routine diabetes care by clinicians (Dale et al 2014)
- Clients are frequently not aware of best oral health practices and availability of community dental service

Aim:

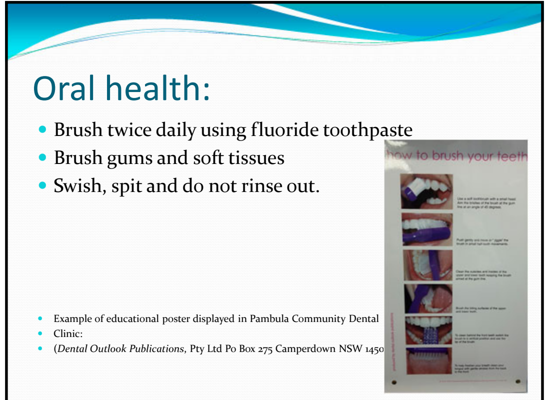
- Increase awareness of clinicians:
- In-service at diabetes educators area meetings, display poster in waiting room/clinical rooms, poster at SDEA conference.
- Increase awareness of clients:
- Display poster and oral health promotion messages in BVHS waiting room, discuss oral health at each session, provide pamphlet, discuss availability of community dental service
- Data collection:
- Retrospective audits of case notes, survey of diabetes educator, audit of frequency of oral health discussion and referrals commencing in June 2020.

Health promotion in waiting room:
Low Sugar Snacks
Try these low sugar snacks instead!

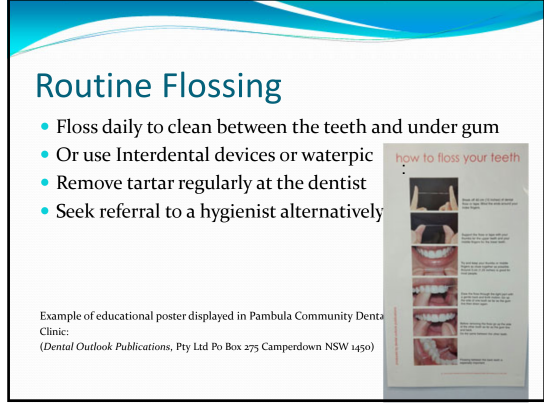
Client education:
Low Sugar Snacks
Oral Health Services
1800 450 046



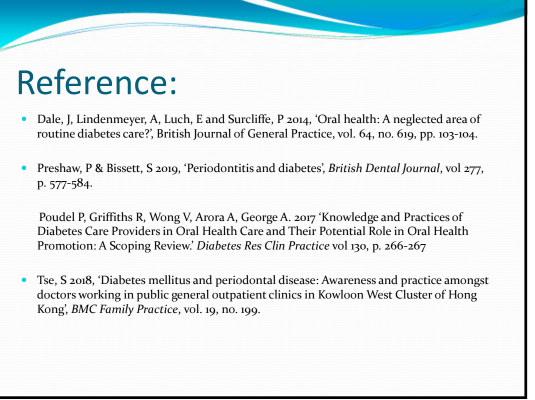
Clinician and client education
DIABETES AND ORAL HEALTH



Oral health:
Brush twice daily using fluoride toothpaste
Brush gums and soft tissues
Swish, spit and do not rinse out.
how to brush your teeth
Example of educational poster displayed in Pambula Community Dental
Clinic:
(Dental Outlook Publications, Pty Ltd Po Box 275 Camperdown NSW 1450



Routine Flossing
Floss daily to clean between the teeth and under gum
Or use Interdental devices or waterpic
Remove tartar regularly at the dentist
Seek referral to a hygienist alternatively
how to floss your teeth
Example of educational poster displayed in Pambula Community Denta
Clinic:
(Dental Outlook Publications, Pty Ltd Po Box 275 Camperdown NSW 1450)



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Poudel P, Griffiths R, Wong V, Arora A, George A. 2017 'Knowledge and Practices of Diabetes Care Providers in Oral Health Care and Their Potential Role in Oral Health Promotion: A Scoping Review.' Diabetes Res Clin Practice vol 130, p. 266-267
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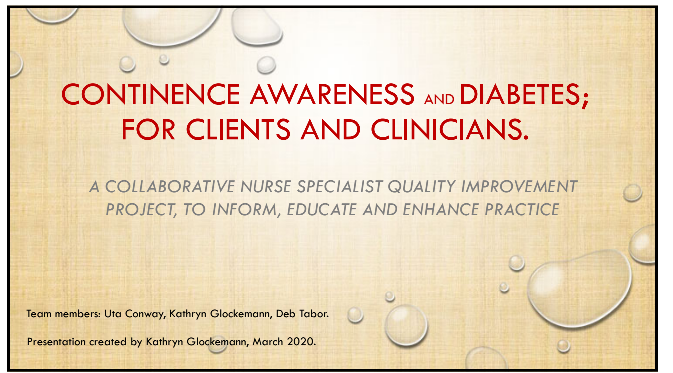


Rationale

There are well documented barriers to client reporting of continence problems. Embarrassment, social stigma, negative preconceptions.

On average people wait 5yrs from onset of symptoms before seeking treatment!

The longer the delay in getting treatment, the harder it is to regain function/control!

We consider that Diabetes Educators and other nursing staff who have frequent contact with people with diabetes are ideally placed to assess and provide timely interventions where continence issues are identified.

The relationship between Diabetes and Incontinence

Obesity: A key factor in the development of T2DM, also a major risk factor for bladder and bowel incontinence.

Nerve damage: Bladder and bowel neuropathy associated with poorly controlled/long term diabetes can cause loss of sensation/awareness, there may be incomplete emptying predisposing to UTIs, kidney damage and constipation.

Reduced immunity: Diabetes interferes with the normal function of the immune system, increasing risk of infections.

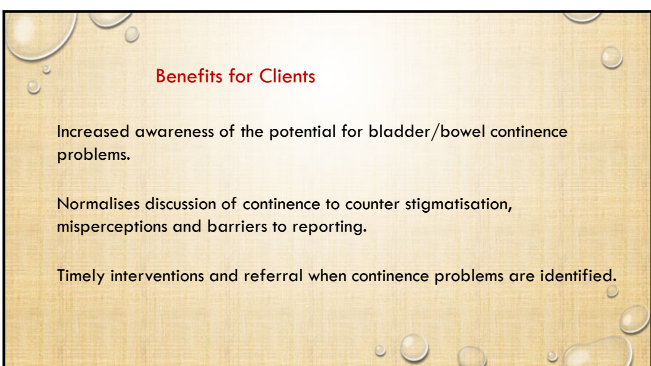
Medication: Some diabetes medications cause diarrhoea (Metformin, Acarbose, Repaglinide). The combination of loose stools and weak pelvic floor can result in bowel incontinence.

Benefits to Clinicians

Diabetes Educators and other clinicians who have a professional interest in supporting clients with Diabetes are offered a 1-hour in-service workshop where they learn the relationship between Diabetes and incontinence and basic concepts in continence assessment and referral.

They learn to recognise 'red flags', e.g. frequency/urgency, nocturia, frequent UTIs, impaired sensation, no warning, episodes of complete loss of bladder/? Neuropathy.

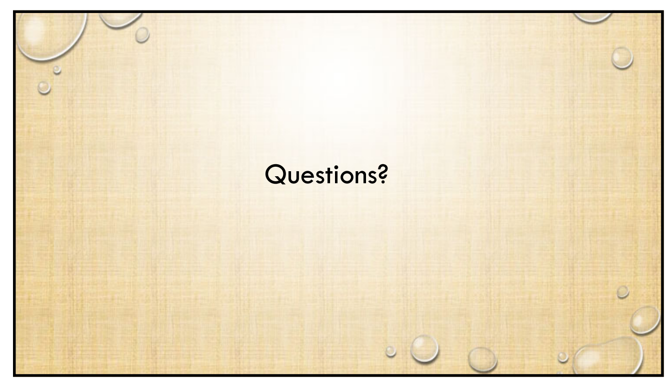
Clinicians who have participated in this education/training are aware and empowered to provide opportunistic interventions in response to their clients reported symptoms.



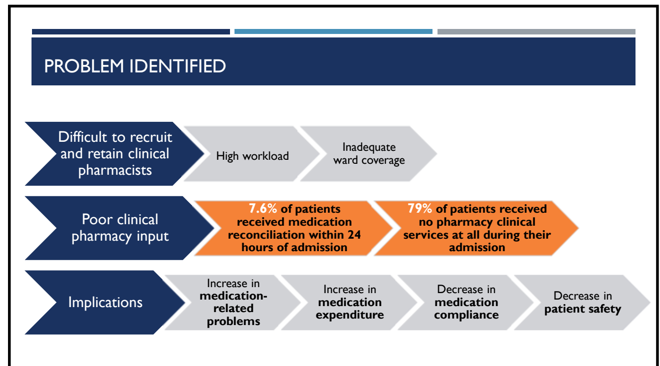
Data collection

- Data period: July to December 2020
- Pre and post in-service questionnaires of workshop with local DE team (also open to community nurses)
- An audit form after workshop to document if continence issues have been discussed
- Keeping data of continence referrals from DE, post in-service. These can be compared with referrals prior to in-service

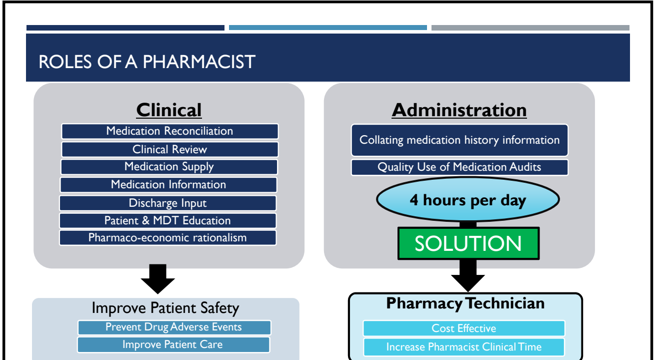
Sources:
• Continence Foundation of Australia, www.continence.org.au
• Australian Government Department of Health, bladderbowel.gov.au


Questions?

CONNECTING COMMUNITIES BETTER WITH WARD BASED PHARMACY TECHNICIAN ROLL OUT IN SOUTH EAST REGIONAL HOSPITAL
Presenter: Amelia Withers.
B. PHARM (HONS) (CLINICAL PHARMACIST/ PROJECT TEAM LEAD PHARMACIST)
Authors: Amelia Withers & Euna Hwang (Chief Pharmacist)
SOUTH EAST REGIONAL HOSPITAL, BEGA, NSW, SNSW LHD
South East Health Research Network (SEHRN)
11th March 2020
NSW GOVERNMENT
Health
Southern NSW
Local Health District



PROBLEM IDENTIFIED
Difficult to recruit and retain clinical pharmacists
High workload
Inadequate ward coverage
Poor clinical pharmacy input
7.6% of patients received medication reconciliation within 24 hours of admission
79% of patients received no pharmacy clinical services at all during their admission
Implications
Increase in medication-related problems
Increase in medication expenditure
Decrease in medication compliance
Decrease in patient safety



ROLES OF A PHARMACIST
Clinical
Medication Reconciliation
Clinical Review
Medication Supply
Medication Information
Discharge Input
Patient & MDT Education
Pharmaco-economic rationalism
Administration
Collating medication history information
Quality Use of Medication Audits
4 hours per day
SOLUTION
Improve Patient Safety
Prevent Drug Adverse Events
Improve Patient Care
Pharmacy Technician
Cost Effective
Increase Pharmacist Clinical Time

PRIOR RESEARCH
Many studies in expanding the technician role
In large, tertiary hospitals only
Studies demonstrated:
Pharmacy technicians shown to be equally successful at conducting medication history interviews 1
With adequate training Pharmacy Technician medication histories are accurate 2,3,4,5
Vastly improved medication reconciliation rates 4,6
Improved the quality of discharge medication 7
Improved medication safety 8
1. Michels, R. M. (2003). Program using pharmacy technicians to obtain medication histories. Am J Health-Syst Pharm, 3(4), 1982-1986.
2. Canning, M. W. (n.d.). Measuring the efficiency and effectiveness of team based pharmacy technicians: A time and motion study. QLD, Australia: Pharmacy Department, The Prince Charles Hospital.
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6. Edmonton, A. (2007). Getting started kit: medication reconciliation prevention of adverse drug events how to guide. Safer Healthcare Now! Campaign. Retrieved from http://www.saferhealth-carenow.ca/Default.aspx?folderId=82&contentId=124
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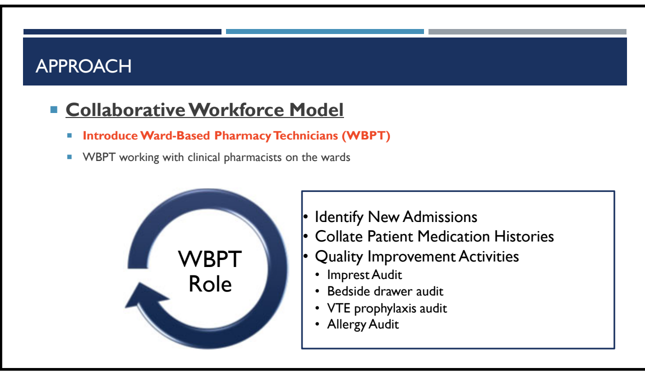
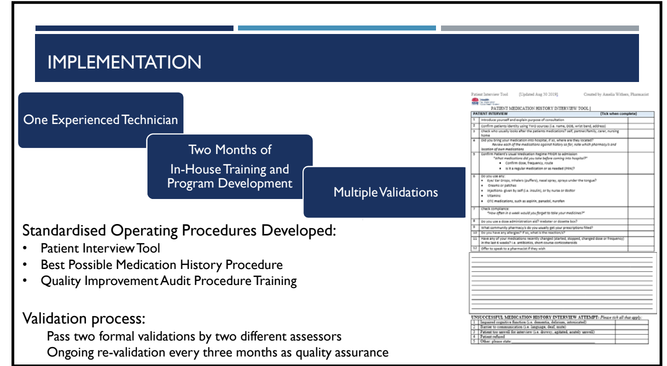
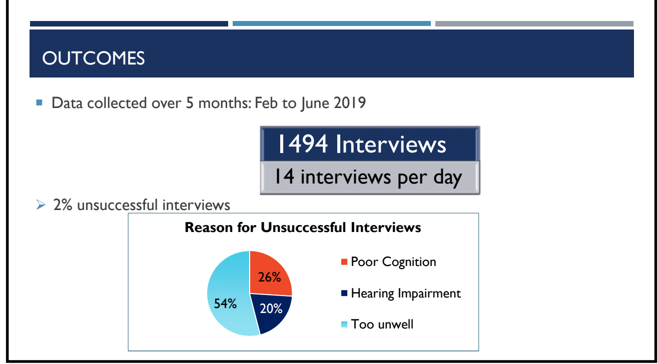
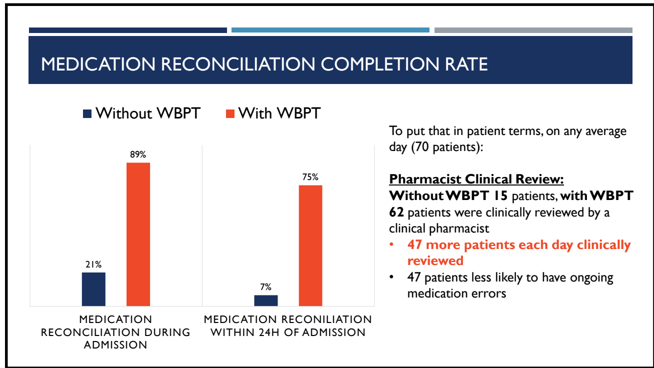


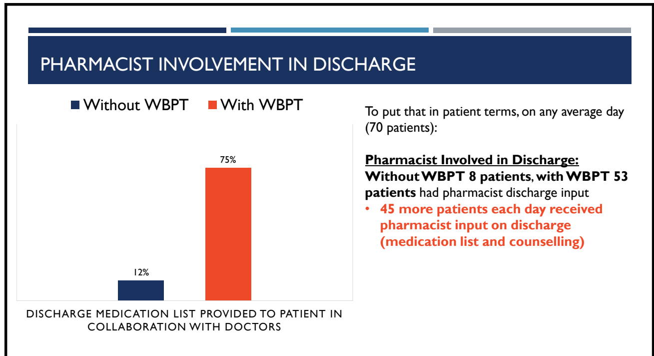
APPROACH
Collaborative Workforce Model
Introduce Ward-Based Pharmacy Technicians (WBPT)
WBPT working with clinical pharmacists on the wards
WBPT Role
Identify New Admissions
Collate Patient Medication Histories
Quality Improvement Activities
Imprest Audit
Bedside drawer audit
VTE prophylaxis audit
Allergy Audit

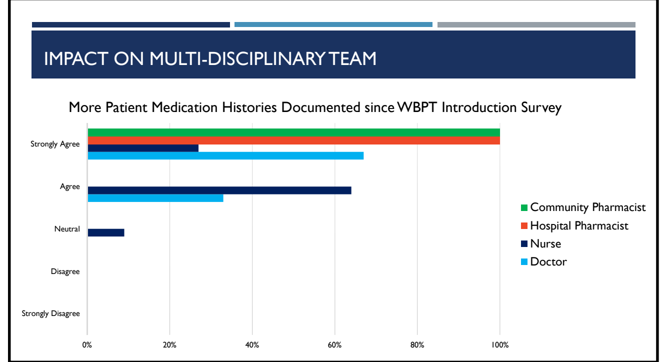


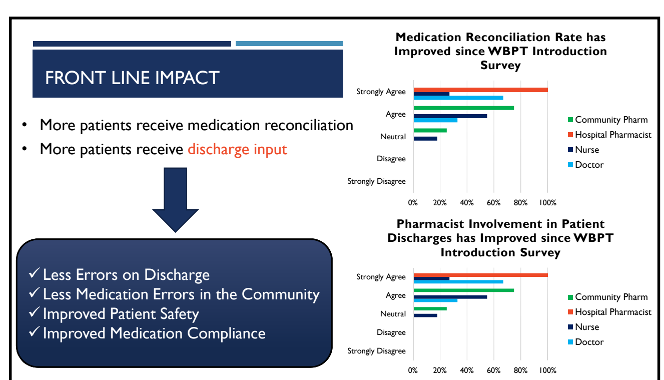
IMPLEMENTATION
One Experienced Technician
Two Months of In-House Training and Program Development
Multiple Validations
Standardised Operating Procedures Developed:
Patient Interview Tool
Best Possible Medication History Procedure
Quality Improvement Audit Procedure Training
Validation process:
Pass two formal validations by two different assessors
Ongoing re-validation every three months as quality assurance

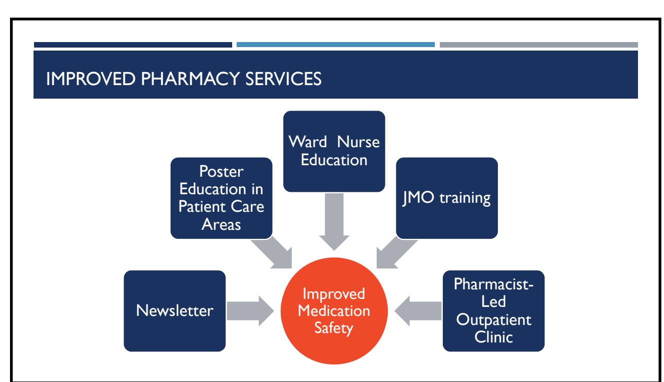

OUTCOMES
Data collected over 5 months: Feb to June 2019
1494 Interviews
14 interviews per day
2% unsuccessful interviews
Reason for Unsuccessful Interviews
26%
20%
54%
Poor Cognition
Hearing Impairment
Too unwell

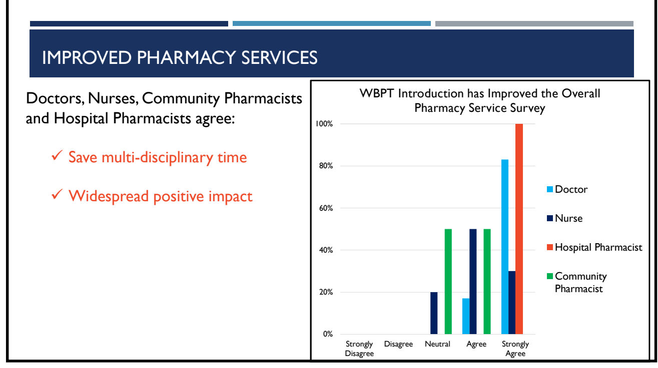

MEDICATION RECONCILIATION COMPLETION RATE
Without WBPT
With WBPT
89%
21%
75%
7%
MEDICATION RECONCILIATION DURING ADMISSION
MEDICATION RECONILIATION WITHIN 24H OF ADMISSION
To put that in patient terms, on any average day (70 patients):
Pharmacist Clinical Review:
Without WBPT 15 patients, with WBPT 62 patients were clinically reviewed by a clinical pharmacist
47 more patients each day clinically reviewed
47 patients less likely to have ongoing medication errors

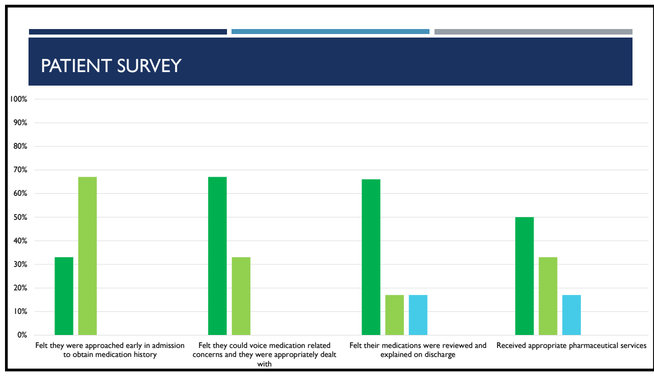

PHARMACIST INVOLVEMENT IN DISCHARGE
Without WBPT
With WBPT
75%
12%
DISCHARGE MEDICATION LIST PROVIDED TO PATIENT IN COLLABORATION WITH DOCTORS
To put that in patient terms, on any average day (70 patients):
Pharmacist Involved in Discharge:
Without WBPT 8 patients, with WBPT 53 patients had pharmacist discharge input
45 more patients each day received pharmacist input on discharge (medication list and counselling)

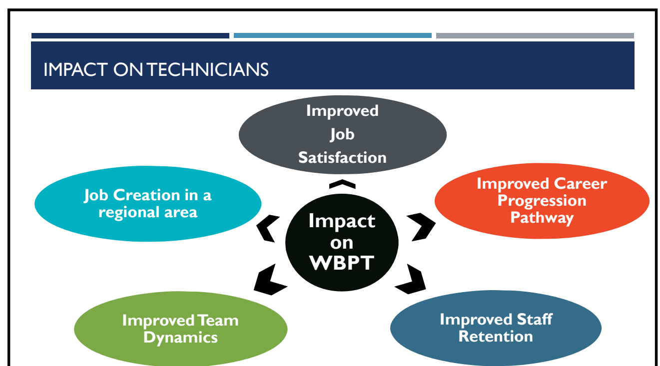

IMPACT ON MULTI-DISCIPLINARY TEAM
More Patient Medication Histories Documented since WBPT Introduction Survey
Strongly Agree
Agree
Neutral
Disagree
Strongly Disagree
0%
20%
40%
60%
80%
100%
Community Pharmacist
Hospital Pharmacist
Nurse
Doctor

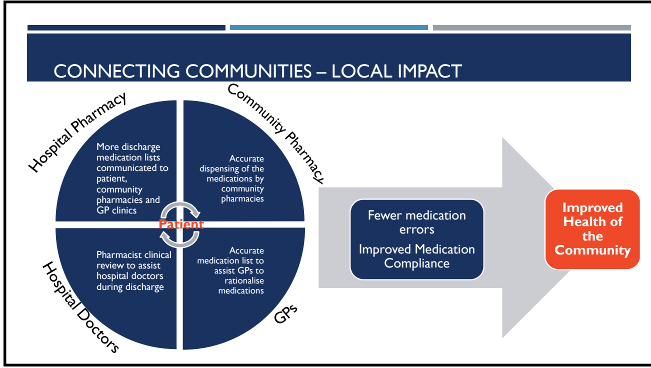

FRONT LINE IMPACT
More patients receive medication reconciliation
More patients receive discharge input
Less Errors on Discharge
Less Medication Errors in the Community
Improved Patient Safety
Improved Medication Compliance
Medication Reconciliation Rate has Improved since WBPT Introduction Survey
Pharmacist Involvement in Patient Discharges has Improved since WBPT Introduction Survey


IMPROVED PHARMACY SERVICES
Ward Nurse Education
Poster Education in Patient Care Areas
JMO training
Newsletter
Improved Medication Safety
Pharmacist-Led Outpatient Clinic

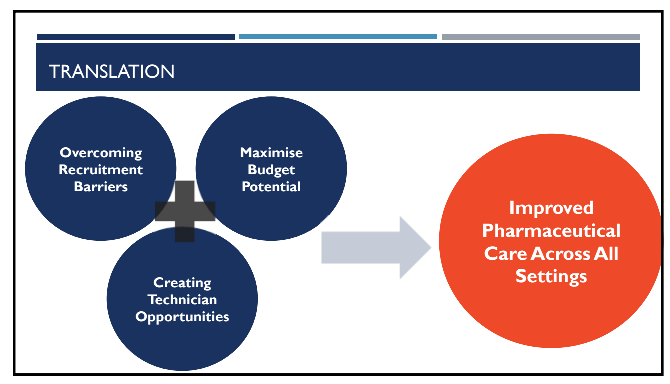

IMPROVED PHARMACY SERVICES
Doctors, Nurses, Community Pharmacists and Hospital Pharmacists agree:
✓ Save multi-disciplinary time
✓ Widespread positive impact
WBPT Introduction has Improved the Overall Pharmacy Service Survey
Doctor
Nurse
Hospital Pharmacist
Community Pharmacist
Strongly Disagree
Disagree
Neutral
Agree
Strongly Agree


PATIENT SURVEY
Felt they were approached early in admission to obtain medication history
Felt they could voice medication related concerns and they were appropriately dealt with
Felt their medications were reviewed and explained on discharge
Received appropriate pharmaceutical services


IMPACT ON TECHNICIANS
Improved Job Satisfaction
Job Creation in a regional area
Improved Career Progression Pathway
Impact on WBPT
Improved Team Dynamics
Improved Staff Retention


CONNECTING COMMUNITIES – LOCAL IMPACT
Hospital Pharmacy
Community Pharmacy
Hospital Doctors
GPs
More discharge medication lists communicated to patient, community pharmacies and GP clinics
Accurate dispensing of the medications by community pharmacies
Pharmacist clinical review to assist hospital doctors during discharge
Accurate medication list to assist GPs to rationalise medications
Patient
Fewer medication errors
Improved Medication Compliance
Improved Health of the Community

TAKE HOME MESSAGES
WBPTs bridged the gap between the clinical pharmacists and rural patients by enabling more efficient and advanced clinical services to be delivered.
Increase in pharmaceutical services delivered to patients
Reduced number of medication errors and readmission
Connecting our communities
This innovative pharmacy workforce model will allow a regional hospital to provide quality pharmaceutical care services and connect our communities together.


TRANSLATION
Overcoming Recruitment Barriers
Maximise Budget Potential
Creating Technician Opportunities
Improved Pharmaceutical Care Across All Settings

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Background

- Chronic Kidney Disease (CKD) patients take multiple medications and have complex medication regimens

Background

- Frequent medication changes increase the risk of the inaccuracy of medication profiles and create compliance problems for patients.

- Subsequently, the incidence of drug-related problems (DRPs) is high, leading to an increased risk of medication-related morbidity, mortality and cost.

Background

- Renal patients at South East Regional Hospital receive a remote monthly clinic review by The Canberra Hospital renal physicians under a renal agreement between TCH and Southern New South Wales Local Health District.

South East Regional Hospital

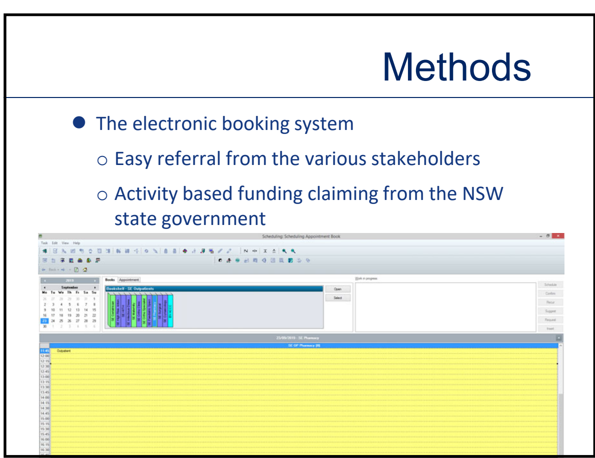
Aim

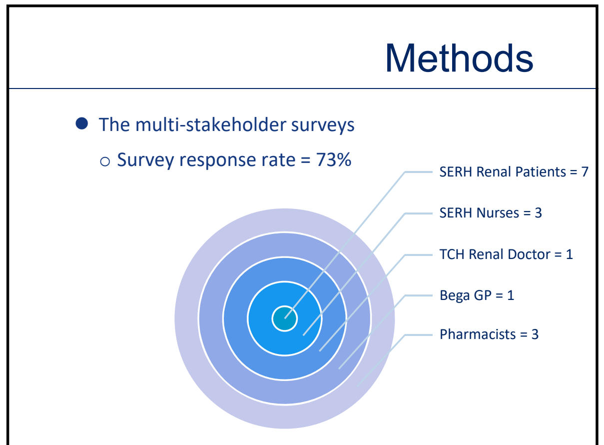
- To evaluate the benefit and feasibility of delivering a clinical pharmacy service to a regional hospital renal outpatients by trialling a pharmacist-led clinic.

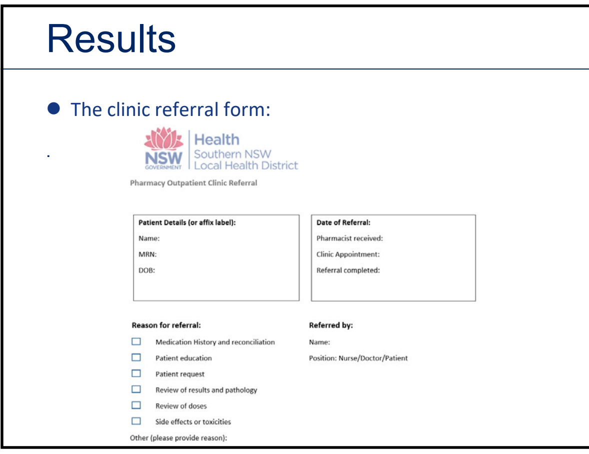
Methods

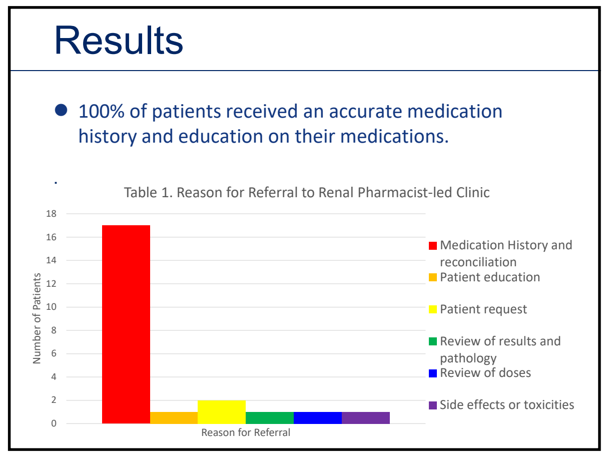
- The clinic was trialed over 4 weeks with 23 patients.
- The clinic ran once a week for 4 hours in the pharmacy department interview room for a private consultation.

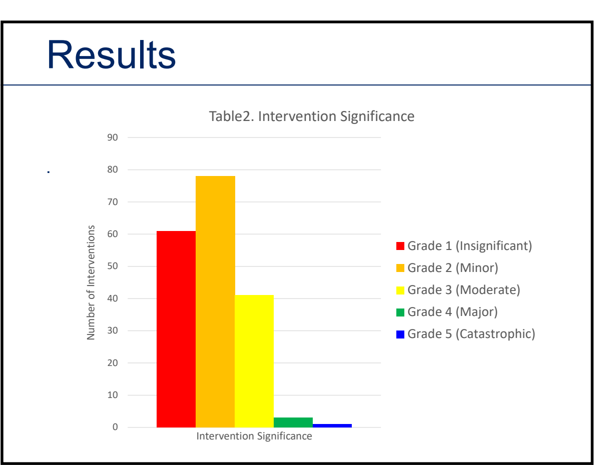
Methods
Any stakeholders could refer renal patients if they believe patients will benefit from clinical pharmacy service or deemed to have DRPs.

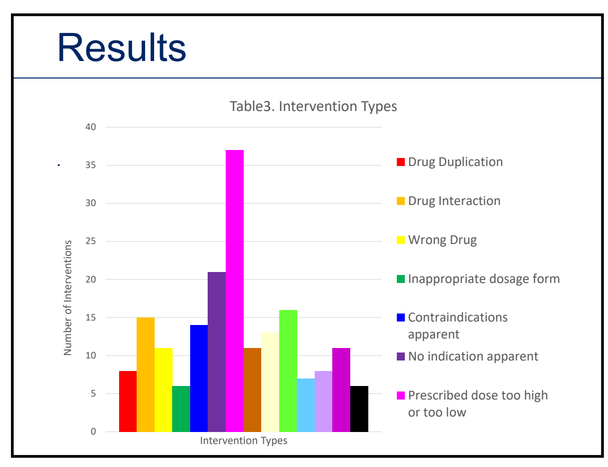

Methods
The electronic booking system
Easy referral from the various stakeholders
Activity based funding claiming from the NSW state government


Methods
The multi-stakeholder surveys
Survey response rate = 73%
SERH Renal Patients = 7
SERH Nurses = 3
TCH Renal Doctor = 1
Bega GP = 1
Pharmacists = 3

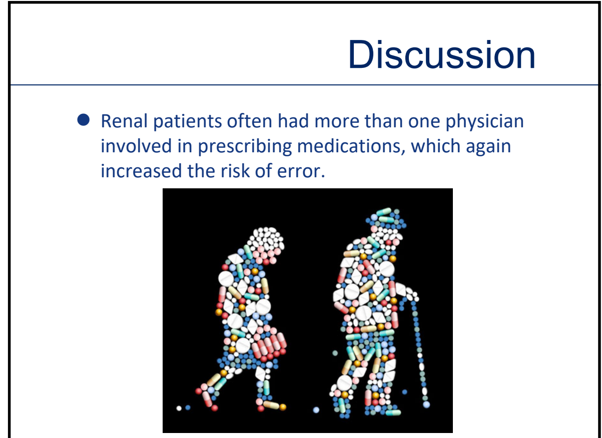

Results
The clinic referral form:
Health
Southern NSW
Local Health District
Pharmacy Outpatient Clinic Referral
Patient Details (or affix label):
Name:
MRN:
DOB:
Date of Referral:
Pharmacist received:
Clinic Appointment:
Referral completed:
Reason for referral:
Medication History and reconciliation
Patient education
Patient request
Review of results and pathology
Review of doses
Side effects or toxicities
Other (please provide reason):
Referred by:
Name:
Position: Nurse/Doctor/Patient

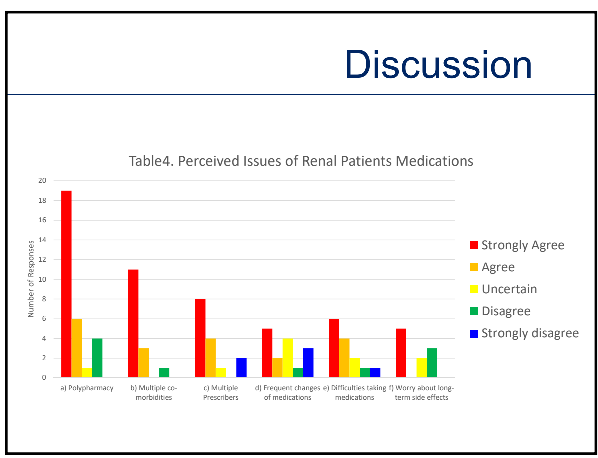

Results
100% of patients received an accurate medication history and education on their medications.
Table 1. Reason for Referral to Renal Pharmacist-led Clinic
Number of Patients
Reason for Referral
Medication History and reconciliation
Patient education
Patient request
Review of results and pathology
Review of doses
Side effects or toxicities

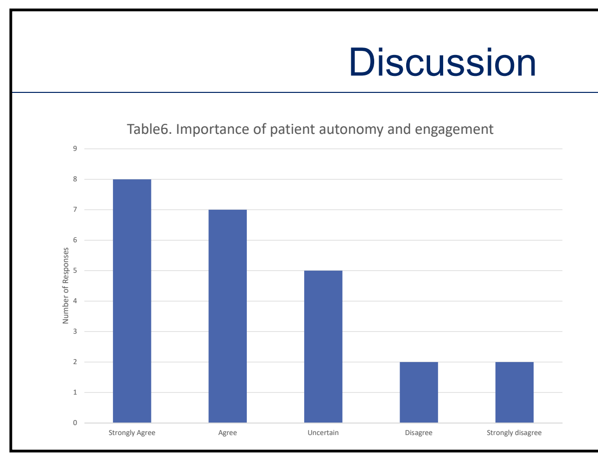

Results
Table2. Intervention Significance
Number of Interventions
Intervention Significance
Grade 1 (Insignificant)
Grade 2 (Minor)
Grade 3 (Moderate)
Grade 4 (Major)
Grade 5 (Catastrophic)

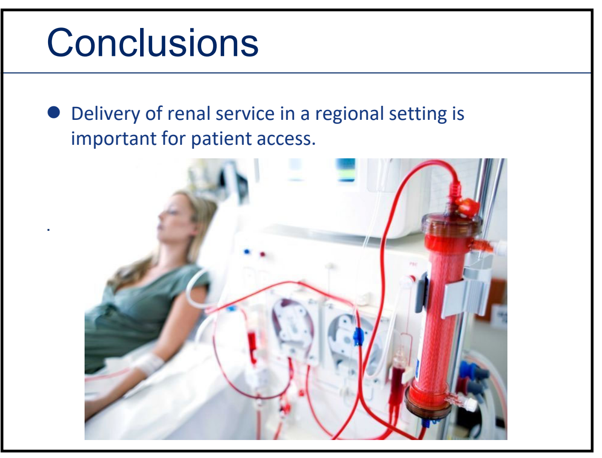

Results
Table3. Intervention Types
Number of Interventions
Intervention Types
Drug Duplication
Drug Interaction
Wrong Drug
Inappropriate dosage form
Contraindications apparent
No indication apparent
Prescribed dose too high or too low

Discussion
Polypharmacy
More than 5 different medications and 12 or more pills each day.


Discussion
Renal patients often had more than one physician involved in prescribing medications, which again increased the risk of error.

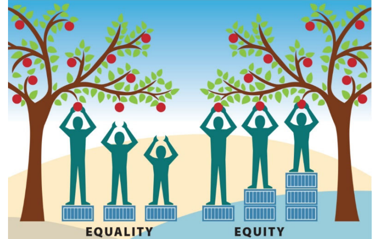

Discussion
Table4. Perceived Issues of Renal Patients Medications
Number of Responses
a) Polypharmacy
b) Multiple co-morbidities
c) Multiple Prescribers
d) Frequent changes of medications
e) Difficulties taking medications
f) Worry about long-term side effects
Strongly Agree
Agree
Uncertain
Disagree
Strongly disagree


Discussion
Table6. Importance of patient autonomy and engagement
Number of Responses
Strongly Agree
Agree
Uncertain
Disagree
Strongly disagree


Conclusions
Delivery of renal service in a regional setting is important for patient access.

Conclusions

- Medication safety and best practices should not be compromised due to regional location or lack of previous pharmacy input.



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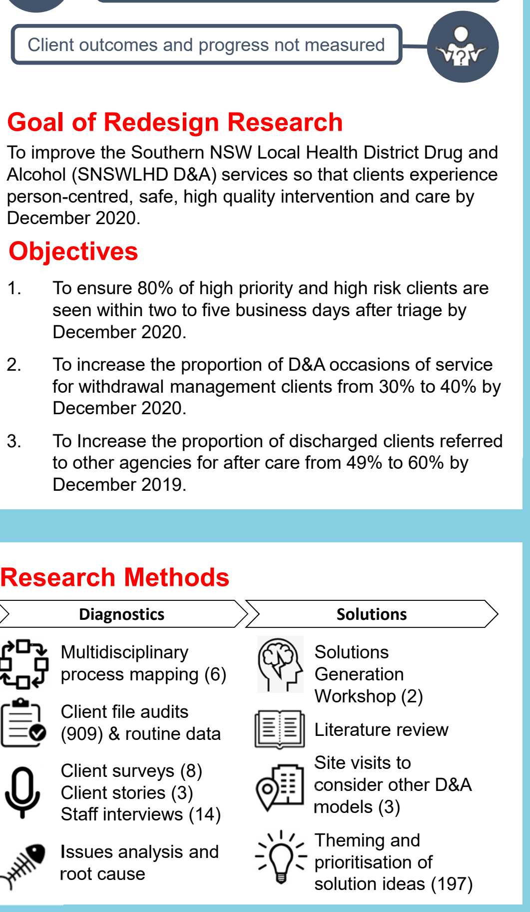
Dealing with the Hard Stuff

Redesigning Drug and Alcohol (D&A) Services in Southern NSW

Problem

- Clients/staff dissatisfied with D&A service
- Higher alcohol-related hospitalisation rates than NSW average for 10+ years — 10+ yrs
- 11 days — Wait time from triage to assessment exceeds recommendations (2-5 days)
- Referred clients not assessed for treatment — 46%
- 0 — No specialist rehab /detox services in the district
- Client outcomes and progress not measured



Goal of Redesign Research

To improve the Southern NSW Local Health District Drug and Alcohol (SNSWLHD D&A) services so that clients experience person-centred, safe, high quality intervention and care by December 2020.

Objectives

1. To ensure 80% of high priority and high risk clients are seen within two to five business days after triage by December 2020.
2. To increase the proportion of D&A occasions of service for withdrawal management clients from 30% to 40% by December 2020.
3. To Increase the proportion of discharged clients referred to other agencies for after care from 49% to 60% by December 2019.

Research Methods

Diagnostics	Solutions
Multidisciplinary process mapping (6)	Solutions Generation Workshop (2)
Client file audits (909) & routine data	Literature review
Client surveys (8) Client stories (3) Staff interviews (14)	Site visits to consider other D&A models (3)
Issues analysis and root cause	Theming and prioritisation of solution ideas (197)

Key Findings

- 27% of 909 files audited showed only one outcome measure entry.
- 73% Care plans and discharges were not informed by evidence-based client self-reported measures.
- Only 14 % of detoxification in the District occurs at home.
- Only 30 % of resources were used to provide acute intervention.
- Inconsistent withdrawal management approaches across hospitals in the district.
- No client experience measures to evaluate care.
- No drug and alcohol service specific strategy for engaging Aboriginal and/or Torres Strait Islander clients in treatment.

Clinical Redesign Solutions to address these issues

Drug and Alcohol Treatment 2020 and beyond

Solution 1 & 2 - A triage system for new referrals and an escalation pathway so high priority referrals are seen in a timely way.

Solution 3 - Withdrawal management pathways are client-centred and evidence-based.

Solution 4 - An Aboriginal engagement strategy developed in partnership with the community using principles of co-design.

Solution 5 - Introduce client experience measure survey to help evaluate care.

Solutions 6 & 7 - Discharge pathways and a MDT forum with service pathways are developed and facilitate stepped care with other services.

EXIT

Initial Results

- D&A referrals being triaged
- 100% clinicians trialling new way of working
- Response times from triage to assessment from 11 days to 5 days

In July 2019, the triage team was trained using a new triage tool for drug and alcohol referrals. Initial results were promising with:-

- 100% referrals being triaged from September 2019, just one month after the roll-out.
- Response times declining from 11 days median to 5 days for high and medium priority clients.

Whilst these results exceeded expectations, the routine review of drug and alcohol response times is now being incorporated into ongoing data collection and auditing. This will promote sustainability.

Next Steps in Clinical Redesign Research

- A newly formed working party established to drive implementation of seven solutions
- Outcome measures and balance measures are being incorporated into monthly and quarterly routine data collection/ reporting processes.
- Routine review of response times from triage/ assessment being introduced.
- Implementation timeline revised to incorporate client/ clinician involvement in implementation
- Evaluation will be aligned to the staged implementation of solutions from December 2019 to December 2020 with adjustments made to plan as needed.
- A working party has been formed to drive implementation of the seven solutions. This working party will make adjustments to implementation plan as needed

Conclusion

The challenges experienced by SNSWLHD in the delivery and monitoring of evidence-based care for clients with D&A issues are also experienced by other D&A services across NSW.

This clinical redesign project will support the district in leading the implementation of D&A standards of clinical care that have been developed at a State-level.

SNSWLHD is building relationships with other care providers to ensure that people who need help the most, get the right service in a timely manner.

Acknowledgements

Sponsors: Cherie Puckett (SNSW), Andy Coe (COORDIARE)

Original Project Team:
Danielle Neves (SNSWLHD)
Gabrielle Mulcahy (SNSWLHD)
Gabrielle O'Kane (COORDINARE)
Skye Russell (ACI)

The project implementation will continue in partnership with COORDINARE. Jo Telenta has replaced Gabrielle O'Kane. This poster has been adapted from a university deliverable developed by the original team.

Contact

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Training Quick Skills:

Providing short, targeted multidisciplinary education sessions for novice and experienced nurses and allied health professionals

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South East Regional Hospital, Southern NSW LHD

PROBLEM / BACKGROUND:

Education is vital for professional development, particularly for novice nurses. However, education time is difficult to arrange in a busy ward environment, so a regular weekly time slot was developed, with management support, to allow staff to attend with minimal interruptions to the ward environment.

These sessions comprised strictly ½ hour sessions: same time, same day, same place, every week.

Easy to remember, easy to find!

Additionally, many ward nurses were unaware of the relevance and role of allied health and specialist nurses. This education forum provides the opportunity to bridge this divide and share skills for better patient outcomes.

METHODS

Questionnaire based surveys of five nurse unit managers' perceptions regarding the Training Quick Skill program was conducted in January 2017. A convenience sample of 14 Training Quick Skills sessions conducted from May to October 2017 revealed that 87 people attended the sessions .Audits of attendance forms identified 68 employees and 19 students. On average six people attended each session. Post session feedback forms were evaluated.

FORMULAE & EQUATIONS

Findings indicate that nurse managers are aware of and support their staff to attend the TQS sessions. The majority of TQS session participants indicated that sessions were relevant to their current practice, that the information provided would directly influence or change their practice and that they found these session informative.

SIGNIFICANCE

Providing short targeted multidisciplinary education sessions for novice and experienced nurses and allied health professionals contributes positively to health workforce development.